INTERGOVERNMENTAL RELATIONS IN HEALTHCARE IN CANADA, 1999-2014

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DECLARATION

I declare that the thesis entitled **"Intergovernmental Relations in Healthcare in Canada, 1999-2014"** submitted by me for the award of the degree of **Doctor of Philosophy** of Jawaharlal Nehru University is my own work.The thesis has not been submitted for any other degree of this University or any other university.

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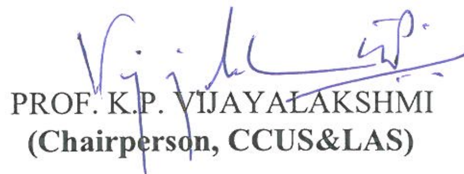

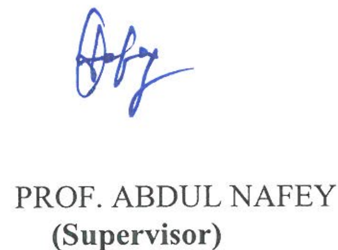

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LIST OF ABBREVIATIONS

APC	Annual Premiers' Conference
BNA	British North America
CAP	Canada Assistance Plan
CHA	Canada Health Act
CHST	Canada Health and Social Transfer
CHT	Canada Health Transfer
CICS	Canadian Intergovernmental Conference Secretariat
CoF	Council of the Federation
CST	Canada Social Transfer
EPF	Established Programmes Financing
FDI	Foreign Direct Investment
FMCs	First Ministers' Conferences
FMMs	First Ministers' Meetings
FPT	Federal-Provincial-Territorial
FTA	Free Trade Agreement
GDP	Gross Domestic Product
GLM	General Linear Model
IGA	Intergovernmental Agreement
IGM	Intergovernmental Management
IGR	Intergovernmental Relations
IPC	Intergovernmental Policy Capacity
MRIs	Magnetic Resonance Imaging

NAFTA	North American Free Trade Agreement
OECD	Organisation of Economic Development and Cooperation
OOP	Out-of-Pocket
PHAC	Public Health Agency of Canada
SARS	Severe Acute Respiratory Syndrome
SUFA	Social Union Framework Agreement
TFF	Territorial Formula Financing
UNESCO	United Nations Educational, Scientific and Cultural Organisation
WHO	World Health Organisation

PREFACE

Despite the refusal of Quebec to sign the Social Union Framework Agreement (SUFA), the agreement signed between the federal, provincial and territorial governments on 4 February 1999 marks an important step in the revitalisation of intergovernmental relations (IGR). The agreement between the First Ministers was intended to clarify the role of federal government regarding social programmes, defines the federal spending powers, and ensures greater accountability in terms of services to the public. The SUFA as a policy response to federal cuts in social transfers, analyses the growing complexity and power of 'conditionalities' and makes an assessmentof the new programmes and mechanisms established to administer SUFA in the area of health care.

Healthcare is constitutionally a provincial domain. The federal government has involved itself in healthcare by co-funding provincial systems and attaching conditions to these funds. Over the last fifteen years i.e.1999 to 2014, there have been significant ups and downs in federal contributions to these provincial systems.

In the case of healthcare, the federal government, especially when the Liberals were in power, defined itself as the guarantor of equality of access to healthcare and resisted efforts by Conservative provincial governments to introduce user fees or increase the role of the private sector. The role of the private sector re-emerged in 2004. It is possible that Canada will eventually move to a new mix of the public and private sectors in healthcare. The process will be an evolutionary one and will require a higher level of consensus in the country as a whole than would otherwise be needed.

As governments undergo periods of economic uncertainty, deficit and debt reduction strategies are developed to find ways to reduce spending, make social programmes more efficient or find alternative means to generate revenues. Canada has experienced periods of bureaucratic growth and austerity many times. When the economy is doing well governments find ways to spend and when it is contracting they undergo severe restraint.Establishing effective IGR is a key challenge to the development of successful health policy. This doctoral monograph attempts to provide such a conceptual framework with the intention that it will serve as a basis for synthesizing existing relevant literature,

identifying gaps in knowledge, and ultimately developing that social sector spending is making Canadian IGR/federalism 'collaborative'.

Managing IGR is an important aspect of Canadian federalism. Canada has never adopted a single approach to federalism. Throughout the history of the Canadian state, federal and provincial governments have designed different social policies, according to different intergovernmental rules and processes. The different models of intergovernmental relations in Canada assess the changes introduced by the Canada Health Act of 1984 in the area of IGR so as to make healthcare system publicly administered,comprehensive, universal, portable and accessible.

The intergovernmental struggle over healthcare is structured on a Constitutional framework and superimposed with competing political dynamics. Since 1999 onwards is also the period of greater privatisationof health services in Canada. Therefore, provinces are so frequently tempted towards greater privatisation of their healthcare systems, which entails higher costs and the costs are shifted from government to the private sphere. The provincial governments get tempted towards privatisation because it reduces their own expenditure on healthcare.

Thus, one needs to understand greater federal involvement through its 'spending powers', greater provincial autonomy as provinces gripe about 'conditionalities', and the need for greater collaboration between governments as SUFA brings in participation of citizens as well in healthcare. Theseand related issues would be the primary focus of the present doctoral work and would span the period between 1999 and 2014.

The doctoral monograph has been divided into six Chapters: four substantive besides one introductory and one concluding Chapters. Chapter I provides a comprehensive idea of research work which includes background of the study, literature review, research questions and objectives and research methodology. Chapter II examines the different models and mechanisms of IGR. It further analyses that IGR plays an important role in the area of healthcare, fiscal and SUFA and also compares Canadian health expenditures and healthcare system with other OECD (Organisation for Economic Cooperation and Development) countries. Chapter III provides an analysis of the Canada Health Act 1984 and also uses the regression model to identify the casual relationship between healthcare

system and policy variables. Chapter IV examines the contents and issues of SUFA and discusses the important reports(Kirby and Romanow) which are the landmark of the Canadian healthcare System. Chapter V examines the federal 'spending power', the evolution of federal healthcare transfers and also focuses on the major findings of the federal support to provinces and territories in the Canada Health transfer whichhave been analysed from the year 2005 to 2015. Finally, Chapter VI summarises the salient arguments of the study and concludes that the federal 'spending power' and its execution remains a primary determent of revitalisation of intergovernmental relations. The SUFA brought greater collaboration among the federal, provincial and territorial governments in the area of healthcare.

CHAPTER I

INTRODUCTION

Background

Intergovernmental relations (IGR) are required when in a political system two or more than two levels of government exist. IGR provide a forum where negotiations, bargaining, compromise and consensus are built so as to resolve conflicts; equally important, IGR become a way to work out a consensus and coordination on the issues of policy formulation and implementation.

IGR are important in all the types of systems, but more so in federations which always have two areas of requiring coordination - 'self rule' and 'shared rule'; as the respective governments jealously guard 'self rule' and fight over the domain under 'shared rule'. The importance to IGR is given in the federal polities since the federal divide is a constitutional divide between two or more tiers of governments; further, the divide is not simply a matter of who legislates or who administers but, more importantly, who raises the revenues and how finances are managed and spent with or without 'conditionalities'. But IGR are not necessarily confined to federal types, they may exist in all the other forms of government, albeit under different dynamics and lesser dynamism.

With the emergence of new policy areas like social security, including healthcare and the environment, etc., the importance of IGR have increased to a great extent. A subject like healthcare involves not only interrelationship between the federal and provincial level of governments, but also between and among the provinces and territories. So often, issues of healthcare get extended to local or municipal level as well. Therefore, one needs to move away from the conventional federal divide of two orders of government and examine the issue of healthcare and possibly all other issues involving the delivery of social services to the citizens in terms of IGR; hence the choice of the term IGR.

Several scholars point out that IGR play a major role in defining the functioning of Canadian federalism. When looking at the history of IGR in Canada, two contrasting

models can be traced: one is that of ‘competitive’ and another of ‘collaborative’ federalism. Cameron and Simeon (2002) analyse the emergence of ‘collaborative’ federalism and bring out some of its unique features. The major factor that decides the model of ‘collaborative’ federalism is provinces’ willingness to invest in horizontal coordination in order to gain strength in limiting federal activities and, thus, make federalism an arrangement of equal partners. In contrast, under ‘competitive’ federalism, states ‘compete’ with each other on specific issues related to jurisdiction or policy formulation, say to attracting business investment in their respective provinces. Of course, IGR do not work in a vacuum, they are affected by a host of factors, such as geography, ethnicity, political orientation and economic resources, etc. In the end, what cannot be denied is that it is the federal dominance that continues to largely shape the Canadian IGR.

IGR in the healthcare area are increasingly important that continue to face new demands and challenges. The Canadian health system is a complex patchwork of policies, legislations and relationships. “The Canada Health Act (CHA), passed on 1 April 1984, of the federal government ensures that provinces and territories meet certain requirements, such as free and universal access to publicly insured healthcare” (Health Canada). Insured health services mean hospital services, physicians’ services and surgical-dental services provided to the insured persons. Insured persons are those who are the residents of a province.

Since its enactment, the Act has been subject to debate as it sought to bring about universality and harmony in the healthcare services for all citizens. The debate focuses on the “national principles” and is part of a broad picture involving factors that are political, fiscal and economic. It also addresses fundamental concerns about the public sector’s role, including that of the federal government, in the healthcare funding and also “the Act lists a set of criteria and conditions that the provinces must follow in order to receive their federal transfer payments, that are: public administration, comprehensiveness, universality, portability, and accessibility” (Health Canada).

In 1999, the Canadian parliament legislated the Social Union Framework Agreement (SUFA) ushering in a new relationship between the federal-provincial and inter-

provincial levels in the larger areas of general health including healthcare, social services and social assistance, post-secondary education, training and labour market development, and Aboriginal peoples (McLean 2000). The dynamics of the healthcare system since SUFA of 1999 capture the essence of working of the Canadian federalism, importantly its changing contours. SUFA has brought in several meaningful changes in IGR, that are: (i) 'collaborative' practices to improve primary healthcare and the quality of health services; (ii) use of the federal 'spending power' to enforce 'conditionalities' on provinces; and (iii) funding earmarked for specific health programmes only. As an intergovernmental agreement, SUFA is described as being a landmark agreement with regard to federal 'spending power'. One needs to understand that SUFA entails commitments on the part of the federal government to "work collaboratively with the provinces in the development of new programmes and not to introduce new programmes without the agreement of a majority of the provinces; and also a commitment to a collaborative mechanism for resolving disputes and to consult further with the provinces and territories one year in advance of any changes in transfer payments" (Wilson 2000).

In Canada, the intergovernmental struggle over healthcare is structured on a Constitutional framework and superimposed with competing political dynamics. The period since 1999 is also the period of greater privatisation of health services in Canada. Therefore, many provinces are so frequently tempted towards greater privatisation of their healthcare systems, which entails higher costs and the costs are shifted from government to the private sphere. Provincial governments get tempted towards privatisation because it reduces their own expenditure on the healthcare.

So one needs to understand greater federal involvement through its 'spending powers', greater provincial autonomy as provinces gripe about 'conditionalities', and the need for greater collaboration between governments as SUFA brings in participation of citizens in the healthcare as well. The study focuses on emerging challenges to the healthcare system. The above mentioned topic and related issues would be the primary focus of the present doctoral work and would span over the period of 15 years.

Literature Review

Available literature on the topic is fairly large and contentious, can be covered under two principles headings:

- ‘Collaborative’ Federalism to ‘Open’ Federalism
- Intergovernmental Relations in Healthcare

(i) ‘Collaborative’ Federalism to ‘Open’ Federalism

Following models of federalism, from the IGR perspective, did emerge in Canada during different political and economic phases: significantly, each model generated its own decision-rules and the level of intergovernmental consensus required for a decision, and each model also has had different implications for policy outcomes. The level of interaction within a federal system includes cooperative consultation and coordination, but also collusion, competition, confrontation, control, conflict and coercion.

Bickerton (2010) coined several terms or models to describe the Canadian federalism such as: collaborative, asymmetrical, bilateral, checkerboard, open, messy, and networked. These models exist in different periods due to their effectiveness, adaptability and flexibility of the Canadian federation and also determine the future character. These models impact on fiscal restraint and constraints on the future use of the federal ‘spending power’, an unsustainable rate of increase in the healthcare costs, and the demographic challenge posed by an aging population and workforce.

Paleker (2006) examines that most of the studies on federalism focus on legislative, financial and administrative relations between the Centre and the States. In his article, he deals with certain theories of federalism. He describes that three types of theories exist, that are: classical theory, origin theory, and functional theory. Each theory of federalism contains elements of validity and usefulness. All the three theories are separated but, at the same time, interrelated and complementary to each other. But taken together they explain federalism as a political system which creates broadly two levels of government in a society with assigned powers and functions arising from a variety of social,

economic, cultural and political factors. Very little attention has been paid to the theory building.

Abrucio and Eduardo José Grin (2015) argue that federalism in IGR may not have the same meaning when trying to identify how federal bodies share public policies; it is difficult to separate these concepts at the theoretical and empirical levels. On the other hand, Elazar (1987 and 1994) and Agranoff (2001) state that “the federal process includes searching for a partnership between the parties to the pact, which is negotiated by way of programmes (policies), and based on commitment and generating consensus, or at the very least preserving the integrity of the bodies. The federal system is supported by a set of techniques (administration and management) for ensuring the collaboration of federative bodies in these programmes.” According to Agranoff (2001) the main challenges are how to overcome the political and legal autonomy of sub-national governments with their administrative focus in order to devise and introduce programmes in a more cooperative way.

Hodgetts (1974) examines the term that “executive federalism is the way in which adjustment of regional and local relations tends to move to the top for resolution in a species of diplomatic conferences. While the new procedures have injected a realistic flexibility into the system, a high price is exacted in terms of Canada's capacity to arrive at an overall set of national policies.”

During 2003-06, the Martin government used its enviable fiscal position to continue the process already underway of ramping up federal spending on social programmes, especially on health. This was being done either in the form of direct federal spending (for example, the Millennium Scholarships and Child Tax Benefit) or by raising federal contributions to shared cost programmes (for example, the Health Accords).

According to White (2013), during the period of Conservative government, Stephen Harper introduced the notion of ‘open’ federalism with the following key elements: “respect for the Constitution and restoration of the balance between the two orders of government; support for strong provinces and the interprovincial Council of the

Federation; limitations on the use of the federal 'spending power'; and measures to fix the fiscal imbalance between the federal and provincial levels of government."

Gregory J. Inwood, Carolyn M. Johns and Patricia L. O'Reilly (2011) talk about

> "Open federalism," as reflected in Stephen Harper's famous Quebec City speech (19 December 2005), indicate that move in the direction of classical federalism. Open federalism embraced the following: "a recognition and a respect for the constitutional division of powers; a recognition that there exists a fiscal imbalance in the federation; a commitment to redress this vertical fiscal imbalance; a related commitment to rein in the federal spending power in areas of exclusive provincial jurisdiction; and, finally, a commitment to work with the Council of the Federation to improve the management and workings of the Canadian federation." And all of this was cast within the political rhetoric of bringing a halt to the "domineering and paternalistic federalism of the Chrétien-Martin Liberals."

D. Cameron and R. Simeon (2002) elaborate that "collaborative federalism" is often portrayed as some type of utopian federal state: "Why can't we all just sit around at the table and resolve our differences?" As Painter (1998) points out, a "slippery concept," there is an agreement that it involves cooperation and collective action on the part of state and federal governments in order to address common problems. Hence, Painter goes on to describe cooperative federalism as "a particular style of intergovernmental relations that evolved out of a perception of a common agenda of problems at the level of 'high politics'." Although applied to the Canadian federalism, Cameron and Simeon (2002) describe "collaborative federalism, as the process by which national goals are achieved, not by the federal government acting alone or by the federal government shaping provincial behaviour through the exercise of its spending power, but by some or all of the governments and the territories acting collectively."

Robert Agranoff and Beryl A. Radin (2014) describe intergovernmental relationships presented IGR as a set of overlaps between national, state, and local units simultaneously. It also presented the relationships as ones in which autonomy and discretion in a single jurisdiction are constrained and, hence, the power and influence available to any one level are significantly limited (Wright 1988). Wright emphasised the role of bargaining between actors in the collaborative model.

Roger Gibbins describes ‘disengagement’ over ‘collaboration’. He characterises “the accumulating ‘messiness’ of the Canadian federalism as growing ‘chaos’ and argues that the Canadian government should revive the values of federalism by restricting its focus to the management of the shared economic space, while disentangling itself from the management of social space.” Canada’s provinces, regarded by Gibbins as “distinct societies”, should be given “room to breathe and capacity to respond to their unique circumstances” (Gibbins 2006). Thus, one needs to understand that the desired result of this disentanglement would be a federal government that acts with more focus and authority on fewer areas of activity, and a more internally differentiated and internally competitive Canada, with more policy experimentation and innovation. To balance this greater decentralisation in social affairs, the federal government must secure and reinforce the economic union and also increase its role in health.”

Further, Robert Young (2006) argues that, at its core, the federal theory informing the concept of open federalism is that of ‘strict constructionism’, whereby the division of powers in the Constitution is seen to be more or less sacrosanct with each level of government adhering to its core responsibilities and staying out of the affairs of the other. At the same time, it recognises Quebec as special, requiring at least a larger international role for that province related to its cultural responsibilities. This implies a bias in favour of strong provinces and a more classical decentralist form of governance.

Young (2006) claims that

> federal interference in the provincial matters increases the likelihood of joint decision traps and high transaction costs, all of which could be avoided or reduced by the federal government ‘disentangling’ from involvement in the jurisdictions that are clearly provincial, such as municipalities. This requires and justifies an increase in the federal transfers and/or tax room to the provinces to allow them to effectively meet their constitutional responsibilities for social affairs. At the same time, Young twins this recommendation for disentanglement with acknowledgement of the impossibility of any complete separation of governments in the modern context and the continued need for federal and provincial governments to collaborate in the key areas, but to do so with clearer rules of engagement, more respect for jurisdiction and greater equality of treatment and partnership is needed.

Young envisages for open federalism has a decentralist thrust, ceding the lead role to provinces through organisations such as the Council of the Federation and infrastructure initiatives such as the Atlantic and Pacific Gateways. In his estimation: "Cooperation with Diversity" best describes the model that fits the concept of open federalism (Leslie 2006).

Csehi (2011) defines that collaboration among the different levels of governance can have many advantages but some disadvantages also. It can lead to mutual learning and capacity building, can provide with new perspectives of old problems, and a kind of a testing-ground. But for the federal systems, the most important element is probably the way it clarifies the roles and responsibilities as far as the competencies are concerned. One of the biggest challenges to collaboration, however, is that it may actually create less transparency and accountability, but may at the same time prove to be very time-consuming and less cost efficient than centralised decision-making.

Csehi further argues cooperative relations may be conducted both horizontally and vertically. However, a horizontal cooperation does not necessarily mean a vertical one. In other words, the constituent units may cooperate without having the same attitude towards the federal level of governance. Competition, on the other hand, means that the different levels of governance, from time to time, challenge one another in carrying out of policy measures (e.g. different tax system). Based on the above discussion, the four different types of federalism have been outlined based on the different form and substance of federalism which is summed up in below table.

Table 1.1: Types of Federalism Based on Different Form and Substance

Form/Substance	Competitive	Cooperative
Co-ordinate	Dual federalism	Collaborative federalism
Concurrent	Un-cooperative federalism	Cooperative federalism

Source: Csehi (2011)

From the above table one can deduce that all four forms of federalism describe structural phenomena, the method of dividing powers among the different levels of governance concerning particular policy areas, with the option to change over time.

One needs to understand that collaborative federalism accounts for cases where formally the system remains coordinated, as far as the policy area in question is concerned, but there is a certain degree of cooperation evolving among the constituent units (and in some cases, the federal level of governance as well). The federal systems, through the different policy areas, may evolve from one type to another. The question is: why certain areas take the collaborative rather than the cooperative form and how the former may eventually turn into the latter?

The different types of federalism account for different modes of governance. Dual and cooperative schemes are the most formalised ones as they rely heavily on the general legal framework that distributes the competences among the different levels of governance.

In other words, collaborative federalism is about finding a way to policy coordination without replacing constituent unit systems by a federally arranged one, but yet ensures harmonisation through co-determination. In a collaborative framework, the allocation of powers is not a settled issue, but rather an open-ended process (Nicolaidis 2001). It is not constitutionally determined, but rather worked out through other more informal means, one of which is IGR. To a certain degree, collaborative federalism injects confederalism to the overall structure of the federal system. As far as competences are concerned, it provides with a non-centralising feature as opposed to the dualist decentralised and the cooperative centralised one.

Cameron and Simeon (2002) further elaborate that collaborative federalism has a great impact on governing methods. Instead of the traditional, formal understanding of responsible government and ministerial accountability, it involves informal, rather diplomatic mechanisms. It is "policymaking through promotion of dialogue, shared understanding of values, mutual engagement, deliberation, consensus-building and agreements. Collaboration is about building commonality, alignment of activities,

negotiation and preparedness to compromise that may involve a lot of power-related elements (highly important for federal structures), such as oversight mechanisms, the ability to force outcomes, compliance, coalition-building and empowerment, etc." Also, in general, there is a shared understanding of roles and responsibilities concerning the actual policy area in a rather informal way.

In the collaborative framework, the question is not how certain issues can be best achieved by the federal level of governance, but rather, how the federal level can contribute to an effective management of a given task? In other words, what matters is what capacity building exercises emerge, develop and may get institutionalised in the overall conduct of IGR?

Bolleyer (2009) argues that

> the establishment of the horizontal Council of the Federation (CoF) in 2003 as the successor to the Annual Premiers' Conference (APC) has been a step towards reorganising interprovincial relations. The frequency of meetings has been increased to a minimum of two per year. The CoF rests on a codified founding agreement and has a mandate to exchange information and to develop shared positions. In addition, it has its own secretariat and is internally differentiated. Despite the growing institutionalisation of this horizontal arrangement, one crucial criterion characterising a highly institutionalised Intergovernmental Agreement (IGA) is not met: the decision-making rule is still that of consensus. Whereas the CoF is institutionalised on a medium level, the First Ministers' Conference (FMC), as the major vertical IGA, is weak. The FMC brings together provincial and territorial premiers and the prime minister and has long been the top of the intergovernmental system. It resolves conflicts on the highest level and gives direction to a network of lower-level meetings. However, all these linkages are informal and cannot generate any reliable patterns of interaction.

Brock (2008) argues that "asymmetrical arrangements among the units of any federation are necessary and even desirable, federal encroachments on provincial jurisdiction in Canada over the past few decades have triggered a protective impulse in the provinces that has resulted in a multiplication of deals recognising provincial differences. The nature and variety of such arrangements are undermining the sense of federal unity and goodwill." And he further argues that to hold the nation together, the federal government should reconsider its role in the federation. But the Conservative government policy of

open federalism begins this reconceptualisation of federal and provincial roles and responsibilities, thus, more constructive and principled action is required.

Herman Bakvis and Douglas Brown (2010) describe

> federalism in comparative sense. Federations need to find ways to encourage essential policy coordination among governments to achieve federation wide political and policy objectives. While administrative federalism, a primary means for achieving coordination in most federal systems is to be found in both Canada and the United States (U.S.), it is more prevalent in the latter, reflecting both differences in federal political culture as well as fundamentally different institutions. A tightly integrated, hierarchical model of administrative federalism is not always as evident as one might expect in the U.S. cases, and where it is, it does not always produce the degree of coordination one might anticipate; that is, greater efforts at coordination from the center may not necessarily result in improved coordination of actual programmes or national policy objectives being met. The Canadian model only rarely conforms to the characteristics of administrative federalism but nonetheless manages to achieve perhaps surprising degrees of coordination through more decentralised processes, which suggests that a high degree of coordination among governments can be achieved without necessarily depending on a system of administrative or regulatory federalism, a system that generally tends to be dominated by the national government.

In this context Kukucha (2013) also argues that

> Stephen Harper's minority Conservative government has allegedly pursued a decentralised vision of the Canadian federalism. This vision includes pledges to limit the federal 'spending power' and the declaration of Québec as a "nation." Controversially, this commitment has also extended to the foreign relations of Canadian provinces. Québec negotiated a bilateral labour mobility agreement with France and was also granted formal standing in Canada's delegation at the United Nations Educational, Scientific and Cultural Organisation (UNESCO). Ottawa has also promised to support an autonomous sub-federal role in trade promotion and the negotiation of international economic agreements. Kukucha further argues that the Canadian provinces have exercised partial and significant autonomy in terms of foreign offices, trade policy, cross-border functional relations, development assistance and the environment, long before the arrival of Harper and the Conservatives. In fact, this policy capacity is due to long-term trends related to the intrusiveness of international trade agreements, federalism's response to these pressures, and the ongoing decentralisation of federal-provincial relations in Canada.

According to Carolyn M. Johns, Patricia L. O'reilly and Gregory J. Inwood (2006) point out that the Canadian federalism has experienced considerable pressure for change and innovation in the recent years. There have been calls for more collaborative federalism

and demands for public sector reforms consistent with the precepts of New Public Management. There is need of some intergovernmental institutional innovation in the arena of federal–provincial–territorial relations (FPT).

They further describe using a conceptual distinction between federalism, IGR, and intergovernmental management (IGM) as the basis of analysing institutional innovation at six levels in the Canadian intergovernmental administrative state, the authors find a differentiated impact with more institutional innovation evident at the micro levels of IGM and innovation more constrained at the macro levels of the administrative state by the traditional institutional infrastructure of executive federalism.

Baracskay (2013) elaborates that the concept of federalism continues to elicit considerable reflection in the literature, particularly in terms of studies that examine the complexities of the public policy process. The division of power and existence of networks of overlapping jurisdictional authority in the federal systems present both opportunities and challenges for IGR. "In terms of opportunities, the prospects for forging collaborative arrangements between various sectors of society have been a particular development in the recent times, given pervasive budgetary and resource constraints. The complex policy arenas, which necessitate considerable coordination between actors, benefit from having a multi-point access and cross communication." Yet, "federalism also inherently presents a variety of challenges to nations, particularly in terms of the resulting fiscal and resource disparities between regions, fragmentation in policy implementation and structure, and legal, institutional and functional inconsistencies from discretionary authority."

Eric P. Polten (2014) states that

> Canada adopted the British North America Act, 1867 through adoption of the Constitution and federalism became one of the main pillars of the new Constitution. The Constitution established an independent central government and guaranteed the legal autonomy of the provinces and their equality in status with the central government. The British North America Act, 1867 did not contain an amending clause, which is the reason why it was the British Parliament that enacted the amendments to the Canadian constitution until 1982. The Constitution Act, 1982 (Constitution Act, 1982 was a part of Schedule B of the Canada Act, 1982 both approved by the British Parliament) finally provided an exclusively

> Canadian amendment procedure and, more importantly, it added the Canadian Charter of Rights and Freedoms to the Canadian constitutional law, making it applicable to all federal and provincial laws.

As Alcantara (2013) mentions, the official participation in Canadian First Ministers' Conferences has long been exclusive to federal and provincial first ministers. In March 1992, however, the membership of this intergovernmental arena was expanded permanently to include territorial premiers.

Painter (1991) says that in all federations, complex systems of IGR evolve to deal with the interdependencies created by overlapping jurisdictions. By dividing and distributing powers in particular ways and by making available mechanisms and channels for resolving differences and reaching agreements, the constitutional framework not only shapes the processes of IGR, but also the outputs.

From the above argument, the performance of the federal system in dealing with issues where policy overlaps exist, two contrasting models of the Canadian IGR can be extracted: an image of competitive federalism, in which governments keep their distance and provide separate bundles of services as they compete for public support, and a contrasting image of collaborative federalism, in which governments come together to co-operate in the provision of public services, with the provincial governments seeking a close involvement in spheres of federal policy that are perceived to intrude on provincial jurisdictions. According to Painter (1991), competition and collaboration have negative and positive outcomes which are shown in the following table.

Table 1.2: Negative and Positive Outcomes of Competition and Collaboration of IGR

IGR	Negative	Positive
Competition	Confrontation	Responsiveness
Collaboration	Collusion	Coordination

Source: Painter(1991)

Thus, collaboration produces better coordinated outcomes that achieve a more satisfying balance of provincial and federal perspectives.

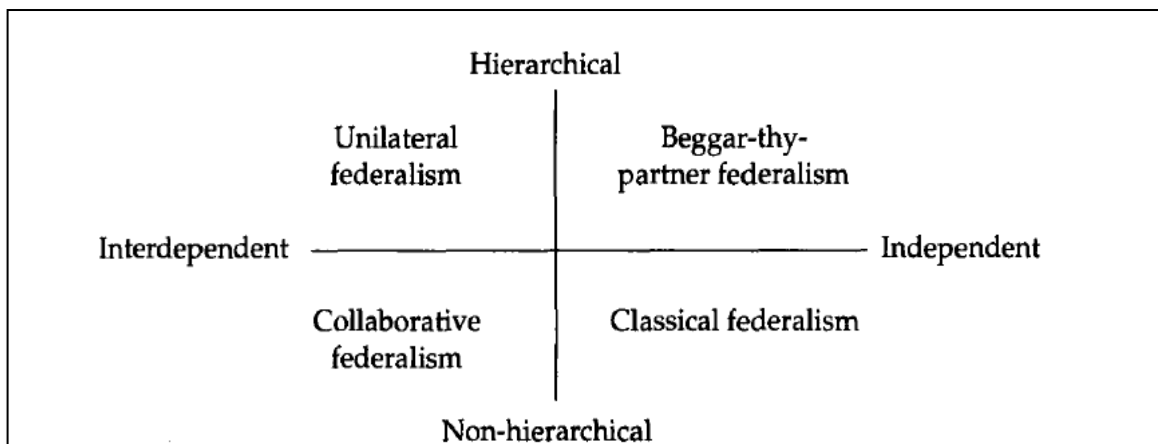
Critics of collaborative federalism point to the barriers to public access that arise when the executives of the two levels of government strike their bargains and to the debilitating effects of provincial vetoes. From the performance of the Canadian federal system, two images of processes of IGR can be extracted: a "competitive" and a "collaborative" image.

In this context, Elinor Ostrom[1] has suggested

> a general framework for analysing institutional arrangements conceived as a set of rules that order the relationships among actors. She proposes a seven-fold classification of the "working rules" governing actors in a variety of "action arenas": (1) boundary rules determine who is eligible to participate; (2) scope rules specify the range of matters over which actors can take action; (3) position rules specify what positions eligible participants hold; (4) authority and procedural rules prescribe what actions particular position holders can take; (5) information rules establish the information that actors may, or must, reveal to others; (6) aggregation rules prescribe the way collective decisions are taken (for example, majority vote or arbitration); and (7) payoff rules specify how costs and benefits are to be distributed as the result of a decision.

Harvey Lazer (2006) further elaborates the classification of intergovernmental regimes in the following table.

Table 1.3:Classification of Intergovernmental Regimes



Source: Lazar(2006)

[1] Elinor Ostrom, "A Method of Institutional Analysis," in F. X. Kaufmann, G. Majone and V. Ostrom, eds., Guidance, Control and Evaluation in the Public Sector (New York: Walter de Gruyter, 1986), 459-75. For an application, see Elinor Ostrom, "Institutional Arrangements and the Commons Dilemma," in Vincent Ostrom, David Feeny and Hartmut Picht, eds., Rethinking Institutional Analysis and Development (San Francisco: International Center for Economic Growth, 1988), 101-39.

Lazar (2006) classified intergovernmental regimes into following types of federalism:

- ‘Collaborative’ federalism occurs when the different orders of government are working together with little or no hierarchy in the relationship among governments. Federal-provincial shared-cost programmes can either be collaborative or unilateral federal depending on whether the governments affected are willing or not partners.
- Classical or ‘disentangled’ federalism involves the different orders of government acting independently of one another and remaining in their own areas of constitutional legislative competence. This can involve only one order of government acting in a particular subject area. Alternatively, it may involve both orders of government acting independently of one another, each within its own constitutional sphere but on matters that involve overlap. This regime type entails non-hierarchy and independence.
- ‘Disentangled’ or classical federalism, there may also be competitive federalism. In situations where only provinces are active, for example, in education, the provincial governments may be striving to outdo one another. In situations where both orders of government are present, as in youth programmes, there may also be a competition between the federal and provincial programmes. Thus, disentangled federalism can be marked by horizontal competition, vertical competition, or both.
- ‘Unilateral’ federalism is an intergovernmental regime in which one order of government imposes its view on the second order of government in an area of the second order’s constitutional legislative competence. In practice, this generally refers to the federal government attaching conditions to financial transfers that it provides to the provincial governments without their enthusiastic approval. All or some provinces are effectively coerced to tolerate the federal conditions because the political and financial costs of foregoing federal revenues would be too large.

- The interdependence of this regime type reflects the fact that the federal government cannot implement its plans without provincial participation, while the provinces rely on some federal funding for the programme in question. The hierarchy reflects the fact that one order of government unilaterally imposes conditions on a programme in an area of exclusive legislative competence of the other.

- 'Beggar-thy-partner' federalism involves both hierarchy and independence. In this form, the different levels of government act independently of one another, the actions of one can effectively impose substantial obligations on the other. There is a form of coercion.

Vandna Bhatia (2011) argues that the 'open federalism' promoted by the Harper government pledges a return to classical federalism in which the federal spending power is limited and jurisdictional roles are respected. This vision may be central to the federal position on transfers, but provincial governments are far from united around it in health policy. Nor have Canadians shown any sign of desiring a federal withdrawal from the healthcare scene. The coming negotiations are bound to reopen these old debates and will test the political will of the federal government in preserving with its vision of a more decentralised federation.

(ii) Intergovernmental Relations in Healthcare

Healthcare has become one of the most important issues in the Canadian society. It has also been one of the most studied areas of public policy. Numerous articles, books and dissertations have discussed what is to be done about "fixing" the "problems" in healthcare. This discussion is not concerned with the actual policy that is developed, but rather how the nature of IGR affects health policy.

According to Wallner (2014),

> due to the division of powers, the federal government has greater revenue raising capacity than the provincial and territorial governments, but lacks the necessary policy authority to shape most of the programmes that constitute the social sector. The provinces enjoy the high degree of authority but lack of necessary fiscal

> resources to fund the various programmes. In this situation, the federal government uses its 'spending power' to invest in the social sector, intervening in areas that constitutionally fall under the provincial and territorial jurisdiction. Using the fiscal capacity, the federal government can attach conditions that provinces and territories have to meet and create programmes that are aligned with "national" priorities. Due to fiscal constraints, the provinces are incapable of independently taking their responsibilities without financial support from the federal government. In other words, the 'water-tight' model of federalism does not exist. There is need of collaborative practices in the social sector to achieve national goals.

According to Lazar (2006), how healthcare policy has been changed in different intergovernmental regimes in Canada elaborates the process of establishing national goals and objectives for healthcare; this was found to vary between the periods of federal-provincial collaboration (1950s-1970s) and the periods of unilateral federalism (1980s-1990s).

The introduction of the two large shared-cost healthcare programmes in the 1950s and 1960s was relatively non-hierarchical. A similar degree of intergovernmental agreement was present with the shift from shared-cost to block-funding in 1977. "But the Canada Health Act (CHA) of 1984 itself, and the way it was established, entailed strong hierarchical elements as did the maintenance of the conditions associated with the CHA when large funding cutbacks associated with the Canada Health and Social Transfer (CHST) were announced in 1995."

The 2000, 2003 and 2004 First Ministers' agreements on healthcare are a partial move back towards the more collaborative approach. In this context, Fierlbeck acknowledges that having both orders of government act independently of one another led to significant savings in the short run. Fierlbeck also observes, however, that a more collaborative approach might well have been more efficient for the long-term planning of healthcare in the provinces.

Overall, both the authors also thought that more collaboration would improve impacts on the public interest. Collaboration implies interdependence, at least to some extent, but without hierarchy. The findings of this research fit very well with the spirit and letter of the Social Union Framework Agreement (SUFA). Its preamble reads: "The following

agreement is based upon a mutual respect between orders of government and a willingness to work more closely together to meet the needs of Canadians."

A number of points flow from these conclusions. The first is that there is no one type of intergovernmental regime that is dominant in the social union. Based on the analysis here, both the classical and collaborative models of federalism are widespread.

Finally, the growth of executive federalism has generated an additional layer of secrecy to the normal layer of secrecy associated with Westminster governments. In this sense, the social union processes remain largely insulated from the scrutiny of federal and provincial legislatures and a diligent press. Even the SUFA itself was not debated and reviewed in Parliament or provincial legislatures before the federal and provincial governments signed the agreement. Whether this is truer of collaborative programmes than disentangled programmes has not made clear through our case studies. Perhaps, because there is so little transparency in government within Canada, it is difficult to make this kind of fine-grained analysis.

According to Wallner (2014), the rules of the Canadian IGR world are vague, largely uncodified and extremely malleable. Over the past few decades, the provinces and territories have taken some steps to address this issue. In 2003, the provinces and territories created the Council of the Federation (CoF) to speak with a strong voice to the federal government while also managing activities that involve all 13 jurisdictions. Two problems arise, that are: First, due to their territorial demarcation, the regional initiatives cannot bring all the governments together. Second, the federal government has demonstrated little willingness to engage with the CoF, undermining its full entrenchment as a permanent feature of the Canadian intergovernmental machinery. Consequently, these initiatives are not addressing the increasing isolation of the federal government from the other members of the federation.

Pierre-Gerlier Forest and Howard A. Palley argue that

> the federal and provincial relationship in healthcare service delivery has been viewed as "cooperative federalism," "collaborative federalism" or "partnership." "Cooperative federalism" implies cooperation between the federal, provincial and territorial levels of government but with the initiative and financial leverage exerted by federal officials (Cameron & Simeon 2002). "Collaborative

> federalism" or "partnership" assumes a more co-equal, provincial-territorial and federal relationship, a relationship closer to "codetermination" (Cameron & Simeon 2002; Courchene 1994; Rasmussen 2001 and White 2002). While the federal and territorial relationship is constitutionally one of federal primacy, in functional terms the federal government usually operates in a "cooperative" or "collaborative" relationship with the territories with respect to the delivery of healthcare services. Thus, regardless of the particular nuance applicable in a particular situation, the federal-provincial-territorial relationship involves the facilitation of the delivery of health services in the provinces by joint meetings and other exchanges resulting in cooperative relationships and health policy developments (including federal funding decisions) between the federal and provincial governmental officials (Adams 2001; Heuglin 2003; and O'Reilly 2001).

Gerard Boychuk argues that the federal government reaps support as the defender of the health system's integrity, but this political capital is dissipating as the provincial problems grow. He argues that the government is following a three-point strategy: "it portrays the health care system as being in crisis; it carefully denies any responsibility for this crisis; and, simultaneously, it ensures Ottawa will have a central role in any remedial prescriptions" (2002). The difficulty with this strategy, however, is the loss of federal legitimacy from earlier federal transfer cuts, which makes both the denial of responsibility and the assignment of a central reform role highly problematic (Boychuk 2002: 125; Adams 2001: 76).

If there is a pattern in recent federal-provincial relations over healthcare, it is of conflict at the peak level over funding, where a period of intensifying provincial demands for more money places the under funding of the health system at the federal government's door. At this point, the federal government feels the need to salvage its credibility as the protector of Medicare and puts some money on the table to secure a deal with the provinces. This is followed by a few months of peace, before provincial demands begin anew. The functioning of the Canadian federalism in the area of healthcare service delivery is characterised by a competition between national fiscal power and the formal constitutional responsibility of the provinces to provide for provincial healthcare.

The new money tool was deployed more successfully in the early 1999, as the promise of substantial new investments tipped negotiations concerning the SUFA greatly in the federal government's favour (Noel 2000). A five-year agreement was reached whereby

the federal government would bring the CHST floor to $14.5 billion for two years, and then $15 billion for an additional three years (through to 2003-04). In return, the premiers agreed that this new money would be fully committed to core health services in accordance with the healthcare priorities of their respective provinces. While this promise did not greatly constrain provincial activity, particularly since there were no reporting requirements, it reduced the supposed flexibility of the CHST (whereby provinces choose how to divide it between health, post-secondary education, and social assistance) and thereby brought the situation somewhat back to practice in effect before the 1977. The February 2000 budget in turn raised the CHST floor to $15.5 billion for 2000-01 to 2003-04(Noel 2000).

The September 2000 health accord between the federal government and the provinces again used the money tool. The federal government promised $18.9 billion worth of graduated CHST cash increases through to 2005-06, raising the transfer's cash portion to $21 billion in the final year (although this included $500 million for Early Childhood Development). A further $1 billion was earmarked for provinces to allow them to acquire modern diagnostic and treatment equipment, especially MRIs (Magnetic Resonance Imaging) (First Ministers' Conference 2000).

In sum, in terms of the money and accountability tools, we note a shift away from the practices associated with the CHA. The federal government clearly lacks the legitimacy to return to setting strong centralised norms and is forced to adopt new forms of bringing provinces to account. At the same time, the federal government has managed to present itself as a central actor in setting out a vision and action plan for the health system.

As Adams (2001) points out, even if the federal government had not undermined its legitimacy to enforce the CHA, it might still need new tools to ensure federal leadership in the current context. The CHA deals with "what" coverage, "who" pays, and "where" coverage applies but does not speak to restructuring imperatives of quality, responsiveness, efficiency, effectiveness, and affordability. With the 2000 and 2003 health accords, the federal government has provided itself with a seat at the table.

After the expiry of legislated funding through the Ten Year Plan to strengthen healthcare as of 1 April 2014, as committed in Budget 2007 (established a new equalisation formula, originally based on a five province standard of fiscal capacity, but now it began to be determined based on a ten province standard), the CHT cash transfer will be allocated to provinces on an equal per capita basis. This commitment will benefit a province that receives less CHT cash per capita than other provinces (Gauthier 2011). The Conservative government of Harper refused to negotiate a new agreement because they argued healthcare delivery as a provincial responsibility and also continue to limit its role to ongoing transfers of money to the provinces.

Cathy Charles, Jonathan Lomas, Mita Giacomini, Vandna Bhatia and Victoria A. Vincent (1997) examine that "the ambiguity of the concept of medical necessity is also advantageous to the federal government. In the face of provincial challenges to the national health insurance standards precipitated by both cost cutting and privatisation ideology, the federal government can use the concept of medical necessity to interpret strategically its view of what constitutes a provincial violation of consistent service coverage and reasonable access to medically necessary services across provinces."

Jennifer Verma et al.(2014) explain that "healthcare in Canada is a complex, diffuse and decentralised arrangement of actors and services. Although it is stated as the 'Canadian healthcare system', there is no single, national health system." She further argues that "rather, there are 14 single-payer, universal and public systems—ten provinces, three northern territories and the federal government—which deliver primary and supplementary health services to select populations, including First Nations, Inuit and Métis people, federal police, veterans, military personnel and inmates in federal prisons. Collectively, these systems are referred as 'Medicare,' each of which grants access to doctors and hospitals, paid for by governments through the Canadian tax contributions."

According to Gregory P. Marchildon (2014), "the history of Canadian Medicare is reviewed to demonstrate the extent to which non-universal alternatives almost became the norm in Canada. While this historical survey focuses on the most critical dimension of universal coverage – the drive to have all Canadians insured on the same terms and conditions – it also addresses the second and third dimensions of universality, the extent

of user fees and the breadth of coverage, respectively." "However, there is no single national narrative on health coverage, in part because of the highly decentralised nature of the Canadian health system. Ultimately, public-sector health system coverage is a policy decision taken at the sub-national level by the provincial rather than the federal government."

Maioni (2013) argues that

> the analysis of the politics of IGR shows that there is a "missing link" in the governance of healthcare in Canada. In the expensive, challenging, and complex world of modern healthcare, what is needed is an increased capacity to be able to analyse and plan in the longer term with clear evidence and coherent implementation. While much of this could be done by the provincial governments, system performance outcomes and the health of Canadians would be greatly enhanced by some kind of policy direction that would benefit from coordination among governments who need to reach out in finding solutions, and stakeholders who need to pull up their stakes and start collaborating. Every other healthcare system in the industrialised world realises this necessity. If the basic attraction of publicly funded healthcare is the ability to spread risk, guarantee access and control costs, we need to think bigger about the kinds of scaling up and value-added services that a larger, pan-Canadian strategy could provide. Otherwise, we are locking ourselves in to widening the gap between money spent and care delivered, without being able to decipher results or respond to challenges, and to being forced to deal with crisis management, rather than long-term investment in healthcare, to the detriment of our collective wealth and the health of Canadians.

Purdy (2015) states that Canada's healthcare system is primarily, but not exclusively, publicly funded and publicly delivered. High-level national health policy is set by the federal government, and partially funded through macro transfer payments to the provinces and territories. However, the provincial and territorial governments play a significant role in the health policy, funding, system oversight and administration. The result is a national framework for health with discrete, separately designed and administered provincial/territorial health systems addressing population needs. Public funding accounts for around 71 per cent of Canada's total healthcare spending, most of the rest is split between private insurers (13 per cent) and consumers' out-of-pocket (OOP) expenses (14 per cent). While public funding and open access to health is a Canadian tenant, the important role of private providers should not be overlooked. Private

providers are a meaningful part of the health delivery system providing both publicly and privately funded services to Canadians. As health systems seek solutions to pressing challenges in meeting escalating health demands with limited resources, there is an emerging focus on seeking new models beyond the traditional public models in place across the country. This focus is not on privatisation of the health system, but rather social innovation whereby novel approaches are being considered in health and human services which maintain social values of access and equity, while delivering improved outcomes through alternative business models involving public, private and non-profit sectors.

Burton H. Kellock and Sylvia LeRoy argue that federal ‘spending power’ is like a "gift theory" because the federal spending, which asserts ownership of public funds, gives government the right to spend these funds as it sees fit, including by imposing special conditions (Scott 1955; Hogg 2000).

According to Hamish Telford, "the federal ‘spending power’ in Canada has been one of the most contentious issues in the federal-provincial relations and central to Quebec’s dissatisfaction with the Canadian federation. The dispute is rooted in two different conceptions of federalism and different perceptions of the federal compact in Canada." Further, Telford says: "English-speaking Canadians tend to view the federal ‘spending power’ as the source of highly valued "national" social programmes, while the government of Québec maintains that the federal ‘spending power’ constitutes an invasion of provincial autonomy and, as such, poses a threat to the cultural distinctiveness of the Quebec nation. The governments of Canada and Quebec have reached a tenuous modus operandi, but the fundamental conflict remains unsolved."

The latest agreement on the ‘spending power’ is included in the SUFA, negotiated by the federal government and the nine English-speaking provincial governments in February 1999. The government of Quebec refused to endorse SUFA. The agreement declares that "[t]he use of the federal spending power under the Constitution has been essential to the development of Canada's social union." "The agreement permits the federal government to continue using its ‘spending power’ to establish new social programmes in the areas of provincial jurisdiction. The federal government agreed that it would not initiate new

social programmes without first negotiating with the provinces, but the agreement also stipulates that the federal government requires only the support of a majority of provinces to proceed with new programmes."

It is evident from the literature review that IGR in healthcare in Canada have been recurring consensus of researchers, policy planners and academics. However, the focus of research and study have been shifting over the fifteen years. The studies focusing exclusively on the linkage between federal IGR and healthcare are traced out. The present study attempts to correlate the three concepts at the same time, i.e. IGR, healthcare and SUFA.

There are a number of studies done on the issue of IGR and healthcare in Canada separately, but there is hardly any study in IGR in healthcare in Canada from 1999-2014. IGR in Canada today are a complex combination of collaboration and competition. The results of executive federalism have taken the form of intergovernmental accords and agreements like SUFA and various health accords. These accords contain commitments to collaboration, co-operation, mechanisms for the resolution of disputes, and commitments to transparency and accountability. There is apparent research gap in this area.

The present study attempts to bridge the gap by critically analysing IGR in the healthcare in Canada. Though, the focus of the study revolves around the current system of healthcare, the study also traces the historical context of the evolution of the system of IGR and healthcare in Canada. The rationale for this study also lies in finding out the necessity of the collaborative practices on healthcare policy and to analyse the step by step, from 1999-2014, important health accords signed between the federal, provincial and territorial governments. The SUFA of 1999 could provide important insight into the system of IGR in healthcare. Therefore, the study makes a modest attempt in this direction. Some sort of dissatisfaction or resentment on account of fiscal imbalance is also visible in health expenditures from 1999-2014. The healthcare challenges today are different from those that were there when the 1984 CHA was designed.

The gaps and overlaps between the different levels of government are also identified, whether it is constitutional ambiguity or fiscal power struggle which stands in the way of governments reaching solutions. One needs to understand from the above literatures that money and jurisdiction are always problematic, but today the stakes around the issues of healthcare financing and the boundaries of policy making are much higher. Social sector spending makes IGR collaborative as well competitive not only between federal-provincial governments, but also among provinces and territories. However, crisis forced the governments to collaborate and create a national system to supply Canadian needs.

The gaps are also identified from the following literature on what led to SUFA, the principles involved in the final agreement, and what it has meant for federal/provincial relations in the area of healthcare over the last fifteen years or so? Above all, who would pick up the bill and for what? The SUFA mainly talks about the funding rather than restructuring the policy and programmes of healthcare.

Definition, Rationale and Scope of the Study

IGR are defined as important interactions between the governmental units of all types and levels and as an interacting network of institutions at national, provincial and local levels. IGR are an evolving system of institutional cooperation that seeks to address the relations of equality and interdependence as defined by the Constitution.

Healthcare in Canada is defined as a set of socialised health insurance plans that provide coverage to all Canadian citizens. It is publicly funded and administered on a provincial or territorial basis, within guidelines set by the federal government.

IGR have shown remarkable flexibility in the different phases in Canada and Canada's federal relationship has coped by and large successfully phases as distinct as that of 'state welfarism' and economic liberalisation.

The present study emphasises on the Canadian healthcare system which is (i) characterised by a substantial degree of direct state intervention, accompanied by significant restrictions on private sector involvement in healthcare. (ii) A provincial subject, the federal government nevertheless has sought to spend on healthcare with a

view to harmonise standards and provision of equal and affordable healthcare to all Canadians, but that was more in the era of 'welfarism' in the decades of 1940s to 1980s. (iii) Things began changing with the passage of CHA in 1984 with federal fiscal transfers coming increasingly with more and more stringent terms and conditions. Be it the era of welfare state or withdrawal of the state from social front, federal intervention in healthcare has remained present. Importantly, healthcare is politically important for both the federal and provincial governments. As the issue of healthcare gained political and electoral prominence, provinces were seen wanting in the 1990s in terms of their ability to provide healthcare and other social services.

Canada is becoming an increasingly decentralised model of governance as each province and territory forms and reforms its own social programmes to suit its particular needs and political orientation. The policy making powers of the federal and provincial governments are defined and protected in the Constitution; however, as governments undergo periods of economic uncertainty, deficit and debt reduction strategies are developed to find ways to reduce spending, make current programmes more efficient or find alternative means to generate revenues. No matter what is the degree of decentralisation and devolution of powers and resources or even privatisation, social services and, more importantly, healthcare requires greater 'collaboration' and coordination between the different orders of governments. Moreover, given the trajectory of federal relations and citizens' expectations and governments of different political hues and levels (federal and provincial), citizens expect public funding of healthcare besides education, etc. In very brief, establishing effective IGR is a key challenge to the development of successful healthcare policy and programmes and Canada has created a complex web of meetings, mechanisms and transfers of resources in this regard.

Research Problems and Questions

Federalism is considered as a grand design of living together and IGR lay down norms of that 'togetherness'. (i) Federalism and, thereby, IGR are a continuous and a dynamic process of harmonising diverse viewpoints, negotiating identities, political interests, and

economic and fiscal resources. (ii) Under the Canadian Constitution, the provincial level of government is granted the majority of legislative powers in the area of healthcare. On the other side, the signing of the SUFA has led to vigorous debates over the extent and meaning of change in the federal-provincial relations and intra-provincial relations besides relations between provincial government and local level authorities. (iii) Focusing on the relationship between federalism and social policy, specifically healthcare, the present study shall examine the shifts healthcare has undergone from the era of welfarism to more market-oriented approaches. And, (iv) the Canadian health system per se is a complex patchwork of policies, legislations and relationships. Access, quality, fairness and cost will always be contentious issues and no clarification of powers, revenue sources or fiscal arrangements can put an end to the debates.

Questions:

The study seeks to answer the following research questions:

1. Why are intergovernmental relations important? What are the different models of intergovernmental relations in Canada? What are the mechanisms of intergovernmental relations in Canada? How intergovernmental relations play an important role in the areas of fiscal, healthcare and SUFA? What is universal health coverage of Canada? What is the role of the federal government in spending on healthcare and comparison of Canada's healthcare system with OECD countries?

2. What is Canada Health Act (CHA)? What is the role of each level of government in healthcare? Why is CHA still subject to debated and birth of Medicare? What are the requirements of the CHA? What is the regression model and what are the results and findings of regression analysis? How is this model important in the Canadian healthcare system?

3. What is SUFA? How has SUFA played an important role in revitalising the intergovernmental relations in Canada, especially with regard to healthcare? What are the recommendations of three major reports for future healthcare reforms in Canada? Why is

Quebec not part of SUFA and also objection to privatisation of healthcare facilities as highlighted by Chaoulli judgment?

4. Why is the role of federal government important in 'spending power'? What is the evolution of federal healthcare transfers? What is Canada Health Transfer and why was it bifurcated from CHST? What kind of federal support in healthcare has been there to provinces and territories from 2005 to 2015?

Hypotheses

Based on the above research questions, the study seeks to test the following hypotheses:

(i) 'Revitalisation' of intergovernmental relations in healthcare is contingent upon related federal 'spending power' under SUFA.

(ii) Social spending makes Canadian intergovernmental relations/federalism 'collaborative'.

Variables

(a) Independent: Intergovernmental Relations

(b) Dependent: Healthcare

(c) Intervening: Political and Institutional Factors

The present doctoral work study employs a research design for three variables in consideration:

$$[a \rightarrow c \rightarrow b]$$

Where 'a' is independent variable, i.e. intergovernmental relations in Canada, 'b' is the dependent variable. It includes healthcare system in Canada since 1999. The study attempts to examine the impact of 'a' upon 'b'.

In the process, 'c' is taken as intervening variable. It examines that since 1999 how intergovernmental relations have affected healthcare system by different political policies with regard to healthcare and federal 'spending power' and evolved due to different

governments (liberal and conservative), which ruled, and their policies in the social sector from the period between 1999 to 2014.

Research Methodology

The present doctoral work will access and utilise the available primary and secondary source material. It would largely be analytical and comparative in nature and would use and compute available data, preferably on an annual basis to examine the IGR, especially the fiscal transfer, federal 'spending power', provincial delivery of services, citizens' participation, and the overall quality and transparency in the Canadian healthcare services.

The study would focus primarily since the 1999 SUFA. The annual data analysed and IGR described, both at the federal-provincial and inter-provincial levels, as stated above, the present study would describe and analyse the trajectory of policies, programmes and mechanisms/ institutions that have been created since the 1984 CHA and, more particularly, since the 1999 SUFA.

The data available at the websites of Canada Health and Statistics Canada and other government websites would be used alongside critical studies and analyses of healthcare done by non-governmental and academic institutions so as to evaluate specific healthcare programmes and schemes. The secondary source material would be used to highlight the diverse perspectives on IGR in the area of healthcare and to delineate how healthcare is changing the pattern of IGR and the very definition of federalism in Canada since 1999.

For statistical analysis and regression model, statistical package R is used along with excel for descriptive analysis of data. R is used in the Chapter 3 where regression analysis is used to study the impact of CHA on the number of registered persons under the healthcare system.Arc GIS 10.2 Software is used in to make Maps. Excel is used to evaluate and compare the quantity of federal transfers to different states and provinces of Canada over the period starting from 2005 to 2015 in the Chapter 5.

Coherence of Research Objective, Type of Data, Sources of Data, Methods and Techniques of Data Collection and Tools of Data Analysis

Research Objective	Types of Data	Sources of Data	Methods and Techniques of Data Collection	Tools of Data Analysis
Measure the extent of federal 'spending power' on healthcare system	Primary Data	Census, Government Reports, Canada Health Act-Annual Report, Department of Finance Canada	Quantitative Method	Statistical Package R (Regression), Excel and ArcGIS 10.2 Software
	Secondary Data	Books and Journals	Qualitative Method	Thematic, and Content Analysis

Chapters Organisation

The doctoral monograph would be spread over six chapters – four substantive besides one introductory and one concluding chapters.

Chapter I: Introduction

Introduction Chapter gives a comprehensive idea of research work, which includes a detailed account of research objectives, literature review, hypotheses, conceptual framework, research methods, data sources and data analysis.

Chapter II: Intergovernmental Relations in Canada

The Chapter delineates various patterns of intergovernmental relations (IGR) and models of federalism that Canada has experienced since the British North America Act of 1867. The Chapter also focuses on mechanisms of intergovernmental relations, health expenditures and universal health coverage and also highlights how the intergovernmental relations played an important role in fiscal, healthcare and SUFA.

Chapter III: Canada Health Act 1984

An attempt has been made here to examine the significant policy and institutional changes that the CHA introduced, particularly in the 'national principles', the system of funding and different mechanisms for policy coordination in the area of healthcare. The use of regression model is also justified in this chapter because the study aims at identifying the causal relationship between the number of registered persons in the healthcare system and various other policy variables taken as an independent variable (the number of hospitals, the number of doctors, etc.).

Chapter IV: The Social Union Framework Agreement 1999

The Chapter analyses in details the debate and the issues that led to the SUFA intergovernmental agreement. The Chapter also describes and analyses the Kirby report of 2002 and the federal Romanow report of 2002 followed by the conclusion of the intergovernmental Health Accord of 2004. It also gives details of the creation of new institutions and mechanisms such as the creation of Canada Health Transfer (CHT) and Canada Social Transfer (CST) in 2004 alongside the establishment of the Health Council of Canada.

Chapter V: Federal 'Spending Power' and Canada Health Transfer

It is critically important to describe the way federal 'spending power' is used as a leverage to change not only the values and norms of intergovernmental relations in Canada but also the very jurisdiction of states. In particular, the Chapter examines the evolution and direction of 'conditionalities' that gradually came to be attached to federal fiscal transfers and grants, especially in the area of healthcare as well as the consequences of such 'conditionalities'. The Chapter also describes diverse methods and mechanisms of federal spending, such as the cost-sharing, block-grants, issue-specific grants, and targeted- and time-bound grants. In this Chapter, the major findings of the federal support to provinces and territories in Canada Health Transfer (CHT) and Canada Social Transfer (CST) have been analysed from the year 2005 to 2015.

Chapter VI: Summary and Conclusion

The final Chapter presents the summary of all the substantive chapters before presenting and analysing the main findings of the research work by way of the principal conclusions in the broader framework of 'collaborative' and 'competitive' IGR. Social sector may call for 'collaborative' IGR and seeking foreign direct investment (FDI) may create 'competitive' federal-provincial and inter-provincial IGR.

CHAPTER II

INTERGOVERNMENTAL RELATIONS IN CANADA

The introductory Chapter provided a fairly elaborated view of the Canadian intergovernmental relations (IGR). The stress of literature was on two themes: (i) 'Collaborative' Federalism to 'Open' Federalism and (ii) Intergovernmental Relations in Healthcare. This study attempts to fill the gap in literature regarding the interplay of these IGR specifically to the healthcare system. The study attempts to analyse the impact of historic events, accords and policy decisions related to the healthcare system in Canada, the way in which healthcare system has evolved over the years. This study also provides due importance to financial aspects of IGR and their relevance for healthcare system of Canada.

The complex structure of federal fiscal relations plays an important role in determining the system of healthcare provision in any country. The financial transfers and policy structure relating to healthcare services are formulated largely by the way in which centre and state government collaborate. The Canadian political structure is primarily collaborative in nature as the federal and provincial governments work collaboratively to attain policy goals and it allows national programmes to work effectively while protecting the autonomy of the provincial governments. The present Chapter is divided into four parts: the first part discusses the importance of IGR and also examines the different models of IGR; the second section explains the different mechanisms of IGR which include discussion of issues that impact variously on IGR in health or fiscal arrangements; and the last section compares Canadian health expenditures with other OECD countries and universal health coverage.

Importance and Models of Intergovernmental Relations

(a) The intergovernmental relations are growing in importance because of the increasing complexities of modern governance. They have become an important feature of federal political systems; however, they are an important part of any political system with more than one level of government. The complexities of this political system increase as policy

making decisions are taken and implemented at different tiers of governance and interaction and cooperation among these tiers becomes crucial for expected policy outcomes.

IGR are the "processes and institutions through which levels of government within a political system interact. All countries, whether unitary or federal, have IGR of some sort, provided they have more than one level of government. IGR have traditionally focused on the formal structures and institutions of IGR, in particular, those connected with the financial arrangements between the levels of government (Painter 2012)." However, IGR also "involve extensive informal processes of exchange and interaction. The older Anglo federations of the USA, Canada, and Australia did not make significant provision for IGR in their Constitutions, assuming instead that the levels of government (the federal (central), provincial (states) and territories) would operate practically separately in the policy subjects allocated to them from the roles and responsibilities mentioned in the Constitution (Fenna 2012)." According to Fenna (2012),

> as governments increased in size and scope during the twentieth century, new issues arose that the original constitutions had not anticipated. The policy areas that had formerly been seen as local matters but now it becomes a matters of national social and economic significance or at least in matters of political and policy interest to national governments. Areas like health, water, the environment roles and responsibilities between levels of government were no longer clear cut and that IGR of some sort was required to establish policy positions and accountabilities as well as administrative protocols between governments. Crucially, with the rise in national income tax as a tool of macroeconomic policy and welfare state redistribution, national governments invariably raised more revenue than they could spend and fiscal transfers to sub-national units became much more important. This dictated that IGR of some sort were necessary.

According to Michael Keating (2012), the purposes of IGR are as follows:

(i) "they serve to resolve conflicts over competences, especially where these are unclearly delineated. This role, present in any federal or devolved system, may be the responsibility of the courts or be dealt political means,"

(ii) "its broader role, overlapping competences are an inevitable feature of modern constitutions, where competences may be described by services (for example

education or policing) or by their policy objective. There are externalities or spillovers from the action of one level of government on to the others,"

(iii) "the conception of ambitious in intergovernmental relations is the role of policy harmonisation, where a case is made on economic, social or political grounds for the same policies to be applied or services provided across the territory of the state." This is particularly relevant where federalism is combined with the national welfare state (Obinger et al. 2005; Greer 2006), and

(iv) there is a need to respond to new challenges that cut across existing divisions of competences with innovative policies.

From the above four points IGR can be more or less coercive or voluntary and organised through a variety of mechanisms.

(b) Managing IGR is an important aspect of the Canadian federalism. Canada has never adopted a single approach to federalism (Banting 2008:137). Throughout the history of the Canada, the federal and provincial governments have designed different social policies, according to different intergovernmental rules and processes.

This section discusses the models of IGRs in Canada. The following models have found their origin in the Canadian Constitution and federalism. Each model generates its own decision rules and the intergovernmental consensus is required for a decision. Each model has different implications for policy outcomes. The functioning of IGR under the Canadian federalism since the British North America Act (BNA) of 1867 has directly added to theoretical developments of IGR and federalism.

There is no single way to describe IGR in Canada. Intergovernmental interaction is required essentially for resolving multijurisdictional problems and to ensure the most efficient and effective use of tax revenues and management resources for the future. In Canada, several models of federalism exist from independence to interdependence of the two orders of government. In the classical form, the federalism works as a watertight compartment model in which each order of government has exclusive authority in its

sphere of jurisdiction and no need to consult or coordinate activities in the other order. The federal system created in 1867 at one hand ended continuum, but at the same time, it was not entirely consistent with the watertight compartment model. The federal government had various instruments it could use in the areas of provincial jurisdiction like the power to appoint lieutenant governors, the declaratory power that allowed the federal government to take over provincial undertakings in the national interest and the power of the governor-general to disallow provincial legislation (Bakvis and Skogstad 2008).

Federalism divides authority among the levels of government and restricts the powers of the central government. There is a considerable literature examining various forms of federalism (Brooks 2009; Cameron and Simeon 2002; and Lazar 2010). For example, Lazar classified "intergovernmental regimes using the following two sets of variables: the extent to which there is independence or interdependence between orders of government; and the extent to which a hierarchical or non-hierarchical relationship prevails." He furthers used this to define four types of regimes, which he termed: "unilateral (hierarchical, interdependent), collaborative (non-hierarchical, interdependent), classical (non-hierarchical, independent), beggar-thy-partner (hierarchical, independent)" (Lazar 2006). In the classical (also termed disentangled) form of federalism, both levels of government carry out functions in the same policy area independently of one another. Political scientists have noted that federalism can be seen as a compromise between homogeneity and diversity, allowing individual jurisdictions to preserve elements of their own identity within the context of a larger nation government (Inwoods 2011).

Since 1930s, the Canadian federalism has moved towards consultation because as governments at both levels expanded the range of their activities, jurisdictions overlapped and policy interdependence intensified. So there is a need for consultation and eventual coordination. Consultation as a model of IGR means that governments exchange information and views before acting independently, leaving the other order to make its own arrangements. Coordination means going beyond consultation to develop mutually acceptable policies and objectives, which each order of government then applies in its own jurisdiction.

During the Second World War, a period of federal dominance, lasting till the early 1960s, gave way to an era of cooperative federalism. Together, fiscally and politically strong provincial governments and a national government armed with a potent 'spending power' created social programmes in the areas of provincial jurisdiction like healthcare, post-secondary education and social assistance.

Cooperative federalism coexisted with competitive federalism. Intergovernmental competition reached the highest level during the 1970s and the early 1980s, when province building ambitions clashed with the unilateral nation building initiatives of Prime Minister Trudeau, including constitutional patriation. Competition receded somewhat during the Mulroney era (1984-93).

Whether it is a cooperative or competitive form, the pattern of IGR which took shape in the 1960s brings elected and appointed officials of the two orders of government and label it as executive federalism. Executive federalism with its dual logic of cooperation and completion is the main feature of Canadian federalism.

The most important forums of intergovernmental consultation and coordination are: First Ministers' Conferences (FMCs) and First Ministers' Meetings (FMMs) of premiers and the prime minister, ministerial meetings (i.e. the meetings of the various ministers holding a particular portfolio, such as health or the environment), the meetings of public servants (officials), and interprovincial meetings of the provinces and the territories, in which the federal government does not take part.

Cooperation is most likely when the stakes are relatively low and the participants share the same values, typically in a substantive policy domain. When the stakes are higher, political elites may not be so willing to compromise and the forums of executive federalism can become venues for intergovernmental competition.

Keith G. Banting (2008) analyses models of federalism,

> [I]n the unilateral model, decisions are taken by both levels of government, with minimum efforts at co-ordination even when decisions at one level have a serious impact on programmes at the other level. Decisions are more flexible, requiring no elaborate intergovernmental consensus and policy can shift dramatically with changes in the government in power, interest-group pressures or public opinion.

> In shared-cost federalism model, the federal government offers financial support to social programmes operated by provincial governments on specific terms. The shared-cost model generates an intermediate level of constraint on government action. Each government makes separate decisions, the federal government decides when, what and how to support provincial programmes and each provincial government must decide whether to accept the money and the terms.

Since the mid to late 1990s in Canada, some analysts identified a new variant that they call "collaborative federalism". Cameron and Simeon (2002) described collaborative federalism as "co-determination of broad national policies". This collaboration takes one of two forms: federal and provincial/territorial governments "working together as equals", or provincial and territorial governments working together to formulate national policy themselves, without the federal government. The three circumstances which promoted collaborative federalism were as follows: the internationalisation of the Canadian political economy in the 1990s; the regionalisation of Canada's national political parties after 1993 with the rise of the Reform and Bloc Quebecois parties; and the third was new public management (Bakvis and Skogstad 2008).

Thus, we can conclude that different models of federalism exist in Canada. Classical federalism has been a model which is used to describe Canada's federalism, but if we look the period from 2006 to 2014, the Conservative government talks about 'open federalism'. In this context, Harmes (2007) examines the federal Conservative party's notion of "open federalism" from a political economy perspective. He says: "Open federalism will appeal to business interests and not to unions and social activists, because it is consistent with the neoliberal approach to federalism which seeks to lock in a free market-oriented policies." He further elaborates:

> The Harper Government has been in power since 2006 and now it has come with a majority mandate, it has very different views regarding intergovernmental interactions. Their commitment to 'Open Federalism' means a more hands-off approach, especially as it relates to social policy which they view as a provincial responsibility. Deborah Coyne (2010) characterizes this as "absentee federalism", as Ottawa refuses to spend money or even engage in conversations about what they consider to be areas of provincial jurisdiction. But what he does not suggest are ways in which provinces and territories in Canada might work together to coordinate their programmes and learn from each other, in order to retain a pan-Canadian approach to the social programmes. The provincial-territorial cooperation without the federal government has a poor track record. This may change in the future with recent commitments from Premiers to work together on

> reform of the health system in light of the recent federal withdrawal. At the Council of the Federation meeting in July 2012 Premiers noted an increased willingness to work together to ensure Canada's continued economic success. Open federalism embraced the following: a recognition and a respect for the constitutional division of powers; a recognition that there exists a fiscal imbalance in the federation; a commitment to redress this vertical fiscal imbalance; a related commitment to rein in the federal spending power in areas of exclusive provincial jurisdiction; and, finally, a commitment to work with the Council of the Federation to improve the management and workings of the Canadian federation.

In short, different models exist and have worked in Canada, such as 'collaborative' federalism, 'cooperative' and 'competitive' federalism. With the Conservative government of Stephen Harper since 2006, scholars are talking about "open federalism" in Canada. It is being argued that under 'open' federalism promoted by the Harper government, the trend is to return to 'classical' federalism which means that federal 'spending power' is limited and jurisdictional roles are respected (Bhatia 2011: 181).

According to Gagnon (2009), the study of Canadian federalism has been strongly influenced by historical institutionalism which includes the formal structures, Constitution, and powers of the institutions and governments over time. Moreover, the field of federalism has been strongly shaped by an interest in the relations between the key institutions and actors of the federation, particularly the relations of state interaction and executive power. Scharpf (1999) call these relations, modes of interaction.

In a federal country like Canada, policy making relationship play a vital role. According to Inwoods (2011), four factors that play a significant role in determining intergovernmental policy capacity (IPC) are: Ideas, Institutions, Actors and Relations, and Relationships. Ideas are political, economic and social ideas which set the context for Canadian federalism and influence the behaviour and actions of policy makers. Institutions include the formal institutions of the Canadian political system and, in particular, the institutions of executive federalism. It includes the Constitution and its division of powers and also the political and administrative institutions of federal, provincial and territorial governments, such as First Ministers' Meetings (FMMs), intergovernmental ministerial councils and secretariats, and central agencies and line departments with intergovernmental units.

Further, Inwood, Johns and O'Reilly (2006) classified into six levels of Intergovernmental Institutional Innovation, which is mentioned in the Table 1. These six levels are divided into two levels, i.e. macro and micro level. Macro level is formal and includes legislative change, formal accountability arrangements, etc., whereas micro level is more informal institutional innovations like informal administrative arrangements, communication networks and relationships of officials.

Table 2.1: Six Levels of Intergovernmental Institutional Innovation

Formal	Joint federal-provincial-territorial institutions	Joint FPT administrative organisations pursue a joint policy, regulatory, or service delivery roles	Macro
	Restructured federal agencies	New/restructured federal institutions to formally incorporate intergovernmental features	
	Intergovernmental departments and central agencies	Traditional intergovernmental administrative agencies	
	Sectoral institutions	Institutional arrangements and implementation institutions in specific policy areas	
	IG partnership agreements	FPT agreements on specific programmes and projects	
Informal	Networks and informal arrangements of officials	Interactions between individual officials	Micro

Source: Inwood, Johns and O'Reilly (2006)

Actors: Political actors include first ministers (prime ministers and premiers), ministers and their political advisors. It also includes administrative actors under the executive branch: the career officials who have primary responsibility for IGR in central agencies and various line departments.

Relations: There are two way relations in this respect (i) the formal institutionalised relations of executive federalism, and (ii) the personal relationships of federalism.

Mechanisms of Intergovernmental Relations

IGR in Canada have expanded their extensive network through mechanisms like First Ministers' Conferences (FMCs), Canadian Intergovernmental Conference Secretariat (CICS), Annual Premier's Conference and Council of Federation (CoF). These mechanisms' interactions have gained importance mainly because, as Simeon (2002) rightly said, "national purposes can often only be achieved be provincial co-operation; provincial goals often require federal assistance. As government roles in social, economic and other policy areas grew, then the need for co-operation and co-ordination and the costs of failing to achieve it - also expanded."

(a) First Ministers' Conferences (FMCs)

FMCs have two aims: firstly, when there is a growing political momentum on some issue on which the two levels of government need to work together and put the issue on the agenda of the FMCs. Secondly, confirming and announce the final decisions on the particular issues. FMCs also play a significant role in the formulation of policies (Saxena 2006). The FMCs are most significant, consist of all the political leaders as members and the Prime Minister as chairman. "They often provide the opportunity for governments to find common purposes and chart general policy directions and also provide a forum for the exchange of information and ideas, and for negotiation and persuasion" (Intergovernmental Affairs). There is no fixed schedule of the meetings, its frequency is totally dependent on the political agenda. Therefore, FMCs are the important part in the IGR in Canada. The number of FMCs and related policy agendas 1963-2015 are as follows:

Table 2.2: Number of FMCs and Related Policy Agendas 1963-2015

Prime Minister	FMCs	Years	Subjects
Lester Pearson	9	1963-1968	Canada Pension Plan, fiscal arrangements, welfare state programmes including post-secondary education and student loans, recommendations of Royal Commission on Bilingualism and Biculturalism
Pierre Trudeau	23	1969-1984	Constitution, economy, fiscal arrangements, unemployment, natural resources, Aboriginal issues
Joe Clark	1	1979	Energy policies
Brian Mulroney	14	1985-1992	Economy, Native issues, Constitution (Meech Lake and Charlottetown Accords), fiscal arrangements
Jean Chretien	7	1993-2003	Economy, fiscal arrangements, Constitution (Section 49), healthcare, social programmes
Paul Martin	2	2004-2005	Healthcare, Aboriginal issues
Stephen Harper		2008-2009	Economy
Justin Trudeau		2015	Economy, Climate Change

Source: Canadian Intergovernmental Conference Secretariat http://www.scics.gc.ca

(b) Annual Premier's Conference (APC)

APC is another more significant intergovernmental institution. It moved into prominence as the frequency of FMCs have declined. APC is held in every August under a rotating chairmanship. This association of provinces and territories has, in recent years, become a full fledged intergovernmental meeting. It was at one of these meetings that the SUFA was initiated, which, many scholars believed, paved the way for 'collaborative

federalism'[1] of 1990s (Jha 2007). It has been held since 1960 and not only endeavours "to harmonize provincial policies but also to develop common provincial policies on matters of federal-provincial concern. On many issues, such co-operation is limited by divergent political orientations and regional interests (Simeon 2002)."

(c) The Canadian Intergovernmental Conference Secretariat (CICS)

It was established to provide administrative services required for the planning and the conduct of the senior-level intergovernmental conference. It was established in 1973, as a result of an agreement reached in the First Ministers' Conference and designated as a department of the federal government by an Order-in-Council dated 29 November 1973. The CICS is a true federal mechanism because both the federal and provincial governments share in its direction, finance, and staffing (Canadian Intergovernmental Conference Secretariat http://www.scics.gc.ca). It was established with the vision and mission to help the governments to work together and come up with an impartial solution. "Over the years, an elaborated framework of intergovernmental relations has arisen with hundreds of daily contacts and transactions and with meeting at every level – bilaterally, regionally and multilaterally. The most visible and important way of conducting formal multilateral relations is by the intergovernmental conferences" (Canadian Intergovernmental Conference Secretariat http://www.scics.gc.ca).

(d) The Council of Federation (CoF)

The CoF is another intergovernmental institution which comprises of Canada's thirteen provincial and territorial Premiers. It was established in 2003 with the objective to:

- Promote interprovincial-territorial cooperation and closer ties between members of the Council, to ultimately strengthen Canada;
- Foster meaningful relations between governments based on respect for the Constitution and recognition of the diversity within the federation;
- Show leadership on issues important to all Canadians

[1] Canadian scholars distinguish 'collaborative federalism' from 'cooperative federalism'. To them, cooperative federalism gave predominant role to federal government, whereas collaborative federalism is more of partnership between the federal and provincial governments. See for detailed discussions, David Cameron and Richard Simeon, "Intergovernmental Relations in Canada: The Emergence of Collaborative Federalism", *Publius: The Journal of Federalism,* vol. 32, no. 2, Spring 2002, pp. 49-71.

The CoF empowers the Premiers to work in collaboration for the stronger federation, by addressing the present and future challenges. It has the potential to allow provinces to articulate an alternative national interest, something that the nature of IGR does not allow them to do independently. As has been noticed, the federal 'spending power' can influence IGR, by examining how the federal government has gained an influence over health policy, a provincial jurisdiction.

In setting out the CoF, the provinces defined the notion of equality in status between the two orders of government. Under that definition, neither order is subordinate to the other. It means each has its own sovereign area of jurisdiction and sufficient resources to exercise its responsibilities (CoF 2003). In other words, both levels are authoritative and competent. All that is implied by the above discussions is that the provincial and federal governments each have their own jurisdictions in which they are autonomous and neither jurisdiction is subordinate to each other.

Including this, there are a number of ministerial meetings at the federal, provincial and territorial levels for the development of consensus over the issues relating to agriculture, education, environment, finance, health, internal trade, sport, tourism and transport etc. From the overall discussion, it can be deduced that the Canadian Constitution has not formally incorporated any intergovernmental structures, a number of informal institutions came into existence as a result of changing political dynamics. The existing mechanisms of IGR are informal because "they are not part of the constitution and thus have no constitutional status nor do they have any basis in law or statute. They have developed on an ad hoc basis, in response to the requirements of the time. They are the medium of forums for the exchange of information, and negotiation and persuasion" (Intergovernmental Affairs http://www.pco-bcp.gc.ca/aia).

Role of Intergovernmental Relations in Fiscal, Social Union Framework Agreement (SUFA) and Healthcare

(a) It is impossible to mention IGR without referring to fiscal arrangements. The federal 'spending power', which dominates fiscal federalism, has the ability to allow the federal government to select its preferred conception of the national vision and implement it. The fiscal imbalance in Canada has created the need for a system of intergovernmental transfers (Norrie and Wilson 2002) and history has privileged the federal government with the majority of fiscal resources. Former Prime Minister Pierre Elliott Trudeau indicated that the federal 'spending power' was the ability of the federal government to spend money for purposes for which it was forbidden to legislate (Telford 2003).

The major form of intergovernmental transfers is the Established Programmes Financing (EPF) funding, which became the Canadian Health and Social Transfer (CHST), and as of 1 April 2004, the Canadian Health Transfer (CHT) and the Canadian Social Transfer (CST) (Department of Finance Canada 2006). Under this formula, the federal government contributes to the partial funding of healthcare and post-secondary education. These funds are transferred to all the provinces on a per capita basis, with some variation between the provinces. The CHT/CST consists of both cash and tax point transfers (Bernier and Irwin 1995).

The second major source of intergovernmental funding is through service provision grants. Initially, one might wonder why this arrangement is a cause for concern to the principle of equality of the provinces. The federal government, however, is able to attach conditions to the transfers under the CHT/CST. The Canada Health Act (CHA) disallows extra-billing and provides evidence of the federal government becoming involved in the provincial competencies, through the use of 'spending power' (Bernier and Irwin1995; and Stevenson 1988). This exemplifies the fact that the federal government has been able to use the federal 'spending power' to enforce the national will.

The power to impose conditions on the provinces, through the 'spending power', gives the federal government a trump card. The 'spending power', as laid out by the

Constitution, allows the federal government to spend on any area, attaching regulations to funding and allows Ottawa to regulate where they cannot legislate (Telford 2003). It restricts the province's ability to act within its own sphere and provides the federal government with a level of influence not intended in the Constitution. "The Constitution Act 1867 (formerly known as the British North America Act) is the legislative act that created Canada. It specifies the responsibilities of the national (federal) government in Ottawa, and of the provinces and territories."

Section 91 of the Constitution Act enumerates the powers given to the national government; it includes the residual power to legislate for the "peace, order, and good government of Canada" on matters not assigned to the provinces. One of the federal powers enumerated in this section was over "Quarantine and the Establishment and Maintenance of Marine Hospitals." Section 91 also gave the federal government the ability to raise money "by any Mode or System of Taxation."

Section 92 of the Constitution Act enumerates the exclusive powers of the provincial legislatures. These include 92 (7): "The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province other than Marine Hospitals" and 92 (16): "Generally all Matters of a merely local or private Nature in the Province."

The court decisions have interpreted these clauses as placing most of the healthcare under provincial jurisdiction. Other powers deemed to fall under the provincial jurisdiction include educational and professional licensure; for that reason, health professionals are registered within a province/territory rather than at the federal level.

The Constitution limited the provinces' power to raise money by restricting them to: "Direct Taxation within the Province in order to the raising of revenue for Provincial Purposes." The provinces do have taxing power (clarified by a 1982 constitutional amendment) over natural resources. The resulting discrepancy in the ability of the different levels of government to raise revenue, along with the differences in wealth and

population base of different provinces, led to what is often called “fiscal federalism”, whereby the federal government has attempted to equalise the fiscal capacity across the country.

Constitutional responsibility for health protection/public health is somewhat ambiguous. Clauses that can be interpreted as making public health a primarily provincial concern include Section 92 (13) of the Constitution Act, which gives the provinces responsibility for “property and civil rights,” and section 92 (16), which gives them responsibility over matters of a “local or private nature” in the province.

Subsequent legal interpretations have accordingly stated that “the provinces have jurisdiction over public health, specifically over sanitation, and the prevention of communicable diseases. However, other clauses can be seen as giving some authority over health protection to the federal government.”

One key implication for healthcare is that it is remarkably difficult for the federal government to play a national role unless the provinces/territories agree to it. As noted above, one of the key vehicles has been fiscal federalism, whereby the federal government gives money to the provinces/territories for specified purposes, with or without strings attached.

(b) The SUFA may provide a new source of centralisation. This is because it allows the federal government to initiate spending when six provinces agree with the programme. Again, this formula gives the federal government more of an advantage. This occurs because the SUFA reaffirms that the federal use of the ‘spending power’ is acceptable (Lazar 2000; and Telford 2003). The acceptance of the use of the federal ‘spending power’ gives the federal government the agenda-setting power in terms of fiscal federalism. The SUFA assumes that now all cost-shared programmes will be initiated by the federal government and not by the provinces. The provinces have been able to insulate themselves somewhat from the unilateral expansion of federal intrusion into their jurisdictions (Lazar 2000), but are not insulated from a retrenchment of the federal

'spending power'. In order to provide a certain level of services, the provinces are still indebted to the federal government.

Although, it is possible for a province to turn down federal money, but it is very rarely done. The opt-out clause of the SUFA also shows how the provinces are subordinate to the federal government. If a province wishes to opt-out of the national programmes, then in order to receive compensation, it must develop a programme with similar goals. That arrangement provides only the illusion of provincial autonomy as the programme that is created must be consistent, but not identical with the goals of the federal programme (Telford 2003).

The Quebec Government's refusal to sign the SUFA agreement is a clear indication that the agreement, at some level, legitimised the use of the federal 'spending power' in provincial jurisdictions (Tremblay 2000). Again, the ability of the federal government to proceed without Quebec indicates that not all provinces need to agree with the federal articulation of the national interest in order to be implemented through the use of the federal 'spending power'.

Originally, the provinces had jurisdiction over the social policy and were able to set the agenda. However, the use of direct federal spending is able to distort provincial priorities (Tremblay 2000). That was one of the strengths of federalism. Each province could solve local problems with local solutions. Policy experimentation and diversity were a definite strength of federalism (Doern and Phidd 1997). The first cost-shared programmes involved Ottawa responding to the actions of the provinces. The most important example of this was the expansion of the hospital insurance system initiated by Tommy Douglas in Saskatchewan. The switch to direct provision has somewhat undercut the legislative initiative of the provinces. The provinces are now forced to respond to initiatives of the federal government. The strategic use of the federal 'spending power' has almost accomplished a complete reversal of the initial policy process, leaving Ottawa with substantial influence over the provincial areas of jurisdiction.

With the federal government in surplus, the initiation of new direct programmes does more to exacerbate the fiscal imbalance than alleviate it, as the provinces are still lacking revenue. As the direct fiscal help has developed via direct individual transfers to the provinces lost one of their areas of exclusivity that were further subjected to the agenda of the federal government. The cut in federal transfers meant that provinces had to cut programmes (Rice 2002). Thus, the federal 'spending power' directly influences the status of the provincial governments. The federal government was able to alter its position in the social policy by changing its use of the federal 'spending power'.

The healthcare and how the federal government has been able to gain enormous influence in a policy area from which it is excluded, according to the Constitution, would be the focus of the next Chapter. Healthcare has now become the main driving force behind IGR (Boychuck 2002). As such, it provides us with an excellent case study to examine the effect of the interplay between the federal 'spending power' and the national interest.

(c) Healthcare has become one of the most important issues in the Canadian society. It has also been one of the most studied areas of the public policy. The CHA of 1984 represents the federal government's attempt to institutionalise a role for itself in health policy by maximising its use of the 'spending power', externalising its internal control over policy direction and budgetary control. The provinces were constrained by their constitutional limits on taxation and the federal government was largely constrained due to the fact that they did not have formal jurisdiction over health policy.

However, the federal government represents "the national interest and nation building, particularly through the development of national social policy. In order to achieve this goal, the federal government had to have control over how the money was spent as they lack formal jurisdiction over healthcare." Moreover: "The provinces are now constrained, not only financially, but by the federal government through the CHA. The federal government, because of its spending power, can in fact direct health policy largely in the direction it sees fit, and the provinces are then constrained to follow that direction, due to their dependence on federal fiscal resources."

The Canadian healthcare system evolved over a number of years, but it reached a national extent involving both the federal and provincial level of government in 1966, with the passage of the Medical Care Act. Under this legislation: “Ottawa contributed directly to programmes that covered the cost of physician services, in addition to continuing funding that was already being contributed towards hospital insurance” (Strick 1999). Under this agreement, the federal government contributed fifty per cent to the cost of hospital and physician services (Veldhuis and Clemans 2003). This was the prevailing nature of the federal-provincial dynamic before the introduction of the CHA. The provinces were responsible for the initiation of new programmes and Ottawa would assist the provinces by paying half the costs.

In 1977, as Coyte and Landon (1990) write, “the federal government switched the way in which it funded social transfers to the provinces from cost sharing programmes to block grants. The provinces would now receive a lump sum of money for social programmes, rather than a sum of money that was dependent upon the level of provincial money spent”. This represented a fundamental shift in the financial aspects of social policy and, specifically, health policy in Canada. Boase (2001) says: “The switch to block funding substantially lowered the ability of Ottawa to enforce the principles of the Medical Care Act”. And Wilson (1985) mentions: “The federal government had altered the way in which it used its spending power. That change created a direct challenge to the current policy lock in, which was based on the foundation of cost sharing. Provinces began to attempt to replace the lost funding under the new EPF (Established Programme Financing) funding framework with the introduction of facility fees, and extra-billing”. The change in funding allowed for a breakdown in the consensus that largely existed in pre-1977 Canada. The reduction of the use of the federal ‘spending power’ forced a reduction in the role that Ottawa was able to play within the existing lock in.

In fact, it is clear that “the adoption of the Canada Health Act was not a bureaucratic decision, but a decision that was driven by political forces”. Monique Begin indicates that when she took over as the federal Minister of Health, “the Department was largely ill-

informed on issues surrounding user fees and proposed options for reform. There were no clear answers as to how much extra-billing was going on, and where it was occurring. The agreement to exchange information between the provinces and federal government never got off the ground." Begin (1988) further says,

> "the Department was in the dark" about issues surrounding user fees. The decision to proceed with the Canada Health Act was certainly an initiative at the political level, supported by lobby groups supporting the federal state apparatus, as the bureaucracy did not have the capacity at this point to enforce current legislation, let alone begin to develop new ideas. After the passage of the EPF legislation, the number of bureaucrats responsible for Health Insurance was nearly cut in half, as the department felt that, with block funding, it would not need to enforce the provisions of the Act as strictly (Begin 1988 quoted in Williams 2006). The province of Alberta was one of the leading proponents in the fight against the Canada Health Act. Dave Russell was Alberta's Minister responsible for hospitals during the debate surrounding the implementation of the CHA. He argued that the federal government was trampling on provincial rights and ignoring the constitution. Additionally, he argued that the reason for the user fees being imposed was the cutback in federal funding and that the federal government could not throw its weight around in healthcare without financial support. Russell argued that this use of the federal spending power went far beyond any other use of the federal spending power. Its use through the CHA was an attempt to control provincial spending priorities (Russell 1984 quoted in Williams 2006).

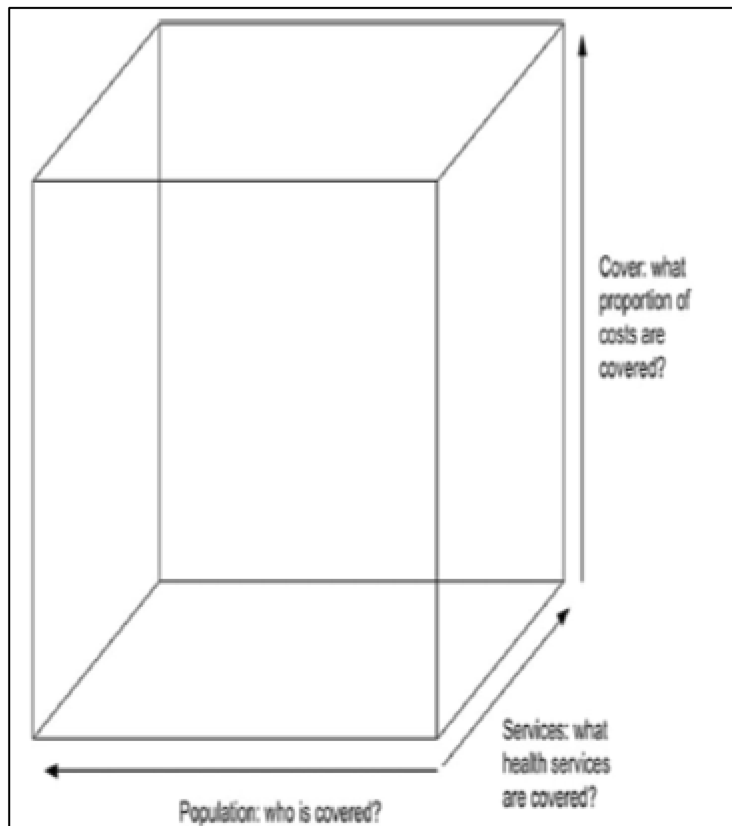
One deduced from the above argument this debate between the federal and provincial levels of government was again taking place at the political level. Most of the debate was not over the technical issues of what actually makes for a better system of delivering healthcare; rather, it centered on broad principles of federalism and provincial rights. Additionally, the entire conflict had largely been bound up in partisan politics. At this time in Canadian history, Alberta was governed by the Conservative Party, whereas the Liberal Party was in power federally.

One needs to understand that "the federal and provincial governments have been jointly involved in the provision of universal publicly insured and administered healthcare to Canadians for decades. In the early post-war decades, federal and provincial governments agreed on the use of conditional intergovernmental grants as the means to build the Canada wide set of healthcare arrangements that exist today."

Canada’s Health Expenditures and Comparative Perspectives to OECD Countries on Health Systems

(a) Canada's healthcare system, commonly known as Medicare, took shape in the 1950s onwards. “Founded on the principles of universality, accessibility, comprehensiveness, portability, and public administration, the system was considered the crown jewel of Canadian social programmes and enjoyed both massive public support and international admiration.”

Figure 2.1: The three dimensions of Universal Health Coverage



Source: World Health Organisation (2010)

As pointed out by the World Health Organisation (WHO), “a more precise definition of universality should address three essential dimensions of the Universal Health Coverage: 1) the population covered, 2) the proportion of direct costs covered, and 3) the services covered”. As mentioned in the Figure 2.1, “the question of universality is multi-

dimensional, and each health system in the world is unique in terms of the degree of universality it will exhibit in terms of population, costs, and services. While no nation has implemented full universality in all three dimensions, a large number of high-income countries, including Canada, achieved universality in terms of the population covered, in which the dimension is generally accorded to the key political and policy priority by most governments" (WHO 2010).

In the above argument, one can deduce that Canada's provinces and territories administer their own universal health insurance programmes, covering all provincial and territorial residents according to their own residency requirements (Health Canada 2013). To qualify for federal financial contributions under the CHT, "provincial and territorial insurance plans must provide first-dollar coverage of medically necessary physician, diagnostic, and hospital services (including inpatient prescription drugs) for all eligible residents. There is no nationally defined statutory benefits package; most public coverage decisions are made by provincial and territorial governments in conjunction with the medical profession." The CHA coverage would be discussed in detail in the next Chapter.

(b) Federal transfers for health play an important role in provincial and territorial governments' spending on healthcare. The total spending on health as a percentage of GDP (Gross Domestic Product) increased from 5.4 per cent in 1960 to 10.4 in 2008. Total spending includes both public and private spending on health. The following periods of rapidly increasing expenditures. The first period was from 1966 to 1971 with the establishment of Medicare, when healthcare expenditures increased from 5.9 to 7.2 per cent. The second period was from 1979 to 1983 when expenditures increased from 6.8 to 8.2 per cent, and the third period was from 1988 to 1992 when expenditures reached 9.8 per cent of GDP. The period of restraint in health spending during the early 1990s is also evident in the figure 2.3. There was, however, a public backlash to the healthcare cuts. Health spending has been increasing since 2000, health spending accounted for 8.8 per cent of GDP and by 2008 the percentage had increased to 10.4 per cent.

Another important trend is the change in the pattern of health spending. The table 2.3 compares the expenditures shares of eight major categories of healthcare expenditures in

1975 and 2010. Over this period, there has been a substantial drop in the share spent on hospitals, reflecting the trend to deliver more services in the community and in the home. The other notable change is the increased share of spending on drugs. In addition to the increasing cost of drugs, this trend probably reflects scientific advances in the development of drugs to treat illnesses more effectively and also the aging population, since seniors are relatively large consumers of pharmaceuticals. The share of "other health spending" has almost tripled. About a third of this increase reflects increases in spending on public health services. Overall, the government sector's share of total health spending declined somewhat from 76.2 per cent in 1975 to just about 70 per cent in 2010 mainly because of the rapid increase in expenditures[2] on drugs, which are largely privately financed.

Table 2.3: Percentage shares of Canadian Healthcare Expenditures by Category

Categories	Year 1975	Year 2010	Percentage point change
Hospitals	44.7	28.9	-15.8
Others Institutions	9.2	9.7	0.5
Physicians	15.1	13.7	-1.4
Other Professionals	9.0	11.1	2.1
Drugs	8.8	16.2	7.4
Capital	4.4	4.3	-0.1
Health Administration	2.8	3.3	0.5
Other Health Spending	4.6	13.1	8.5

Source: Canadian Institute for Health Information, National Health Expenditures Trends, 1975 to 2010.

[2] Approximately 70 per cent of total health expenditures in Canada is financed from taxation by the provincial and federal governments. The remainder comes from individual out-of-pocket payments; private health insurance (Canadian Institute for Health Information 2007). Provincial governments are responsible for the final health expenditures within their jurisdictions. The dominant sources of funding are the general revenue funds (GRF) of provincial government and the financial transfers from the federal government. In addition, some provinces (Alberta, British Columbia, and Ontario) raise supplementary health revenues through earmarked taxes known as 'premiums'.

(c) This section compares the Canadian health system with other OECD countries. The Table 2.4 selected health statistics from nine OECD countries. In the first column, we look at important characteristics of each country: the proportion of seniors in the population (defined as persons of 65 years of age and over). Since seniors are the biggest consumers of healthcare services, this statistic gives an indication of the demand for health services in each country. In comparison, Canada has a relatively young population as New Zealand, Australia, and the United States (U.S).

The second column shows the number of practicing doctors per 1,000 residents. This statistic gives us an indication of the supply of health services by country. Canada along with Japan has the lowest figure, with 2.2 doctors per 1,000 residents. Germany, France, and Sweden have substantially more.

The next column provides some information on the output of the healthcare system, measure of the health of the population. In the nine countries, Canada's average life expectancy of 80.7 years ranks below that of Japan, Sweden, Australia, and France. The U.S. has the lowest average life expectancy of 77.9 years. The last column compares the expenditures on health services across countries. Canada's share of GDP devoted to healthcare is the fourth highest among the nine countries.

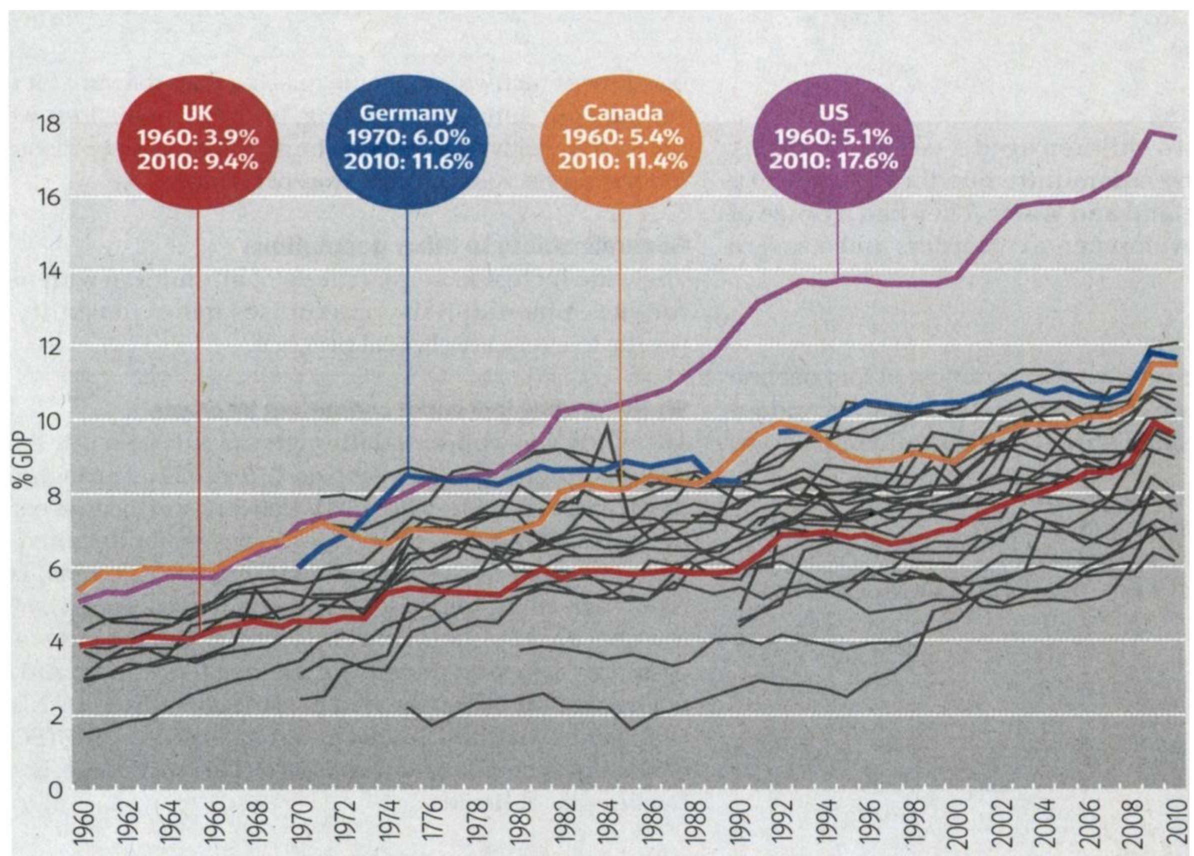
Among all OECD countries, Canada ranks seventh after the U.S., France, Belgium, Switzerland, Germany, and Austria. Although, the U.S. devotes a substantially larger percentage of GDP to healthcare, life expectancy is not so good as compared to Canada. The Swedish health outcomes are substantially better than Canada, despite the greater proportion of seniors in the Swedish population and a smaller percentage of GDP devoted to healthcare. The above data of nine countries has differences in the health outcomes because of many factors which are unrelated to the healthcare system such as the income support system. Canada with other OECD countries in terms of health spending has increased since 1990 as shows in the Figure 2.2.

Table 2.4: Selected Health Statistics for OECD Countries, 2007

Countries	Percentage of population over 65	Physicians per 1000 Population	Total expenditures as a Percentage of GDP
Australia	13.1	3.2	8.5
Canada	13.5	2.2	10.1
France	16.6	3.4	11.0
Germany	20.2	3.8	10.4
Japan	21.5	2.2	8.1
New Zealand	12.5	2.3	9.1
Sweden	17.4	3.6	9.1
United Kingdom	15.5	2.5	8.4
United States	12.6	2.6	15.7

Source: OECD (2010) Health Data

Fig 2.2 Total (Public plus Private) Health Spending as a percentage of GDP in OECD Countries, 1960-2010



Source: OECD (2013) Health Data

Conclusion

In conclusion, it can be stated that models of federalism, from cooperative to 'collaborative' federalism from the IGR perspective, did emerge in Canada during different political and economic phases: significantly, each model generated its own decision rules and the level of intergovernmental consensus required for a decision, and each model also has had different implications for policy outcomes. The result of these developments in the policy space of intergovernmental transfers is a complex system of finance and implementation of health related policies and initiatives in the country. Though, the primary responsibility of healthcare provision lies with the provinces, the onus of financing these services lies with the federal government. This system gave way to financial and other conflicts among the federal and provincial governments which were also political in nature, at time differences in political regime in the federal and provincial level lead to conflicts. The current system provides greater ability to rich states or to states which can generate higher tax revenues to provide efficient and better quality healthcare facilities to their residents. Resource scarce provinces are resorting to cost sharing methods to manage the changes in funding sources introduced through the CHA.

As Jennifer Smith (2002) points out, the Constitution is one basis for arguing that the provinces in Canada are autonomous, although the Constitution itself does not provide a clear answer. All the provincial governments in Canada are supreme within their jurisdiction as set out in the Constitution, but certain provisions of the Constitution apply only to specific regions of the country. Each province has a series of enumerated legislative powers and certain provisions of the amending formula pointing towards provincial equality. It is these factors that form the constitutional basis for the belief that the provinces are autonomous. However, we must also note that there is an asymmetrical nature to the provinces as well. The provinces entered confederation differently and were not equal in the founding of Canada.

The nature of IGR leaves Canada with one actor representing a national vision and ten actors representing distinct regional interests that cannot be underestimated for its importance. Rather than concluding as Simeon did, that this fact indicates the diplomatic nature of IGR, this fact allows us to conclude that the Canadian IGR are distinctly

different from international relations. It is true that in international relations distinct actors come together to negotiate on behalf of their people and attempt to garner the best possible policy outcomes.

The importance of IGR in healthcare policy can be ascertained from the changes in the pattern of healthcare provision services, which were in sync with changes in policy decisions. It can be concluded that the IGR in healthcare system in Canada are collaborative in nature, the changing policies of the government and the shifting focus of policy makers have changed the way in which the collaboration has evolved over the decades, but it has not changed the requirement of synergy which is needed between different layers of governance to successfully deliver social services in Canada.

The prevailing systems of IGR have shown their impact on the CHA, which was meant to provide quality healthcare at affordable prices to Canadian citizens. The nature of healthcare services (public good) requires active government intervention in the area for efficient provision of same and the CHA was a step in this direction. The next Chapter elaborates upon the intricacies of CHA in this context.

CHAPTER III

CANADA HEALTH ACT 1984

The previous Chapter dealt with the complex nature of intergovernmental relations (IGR) of Canada along with its mechanisms, issues and impacts in different areas. This Chapter connects Canada Health Act (CHA) with IGR as the outcomes of the CHA are dependent on the unique characteristics of IGR in the country. The federal government provides provincial and territorial programmes, with conditions on adherence to the five underlying principles of the CHA, the law that sets pan-Canadian standards for medically necessary hospitals, diagnostic and physician services. The principles state that each provincial healthcare insurance plan needs to be publicly administrated, comprehensive in coverage, universal and portable across provinces, and accessible (Rudoler and Allin 2014).The Chapter gives an overview of the CHA of 1984 and its relevance in the present scenario. It attempts to analyse the significance of the Canadian social policies and structure of IGR to provision of healthcare services. Quantitative analysis has been used for data analysis of the past fifteen years to draw conclusions regarding effectiveness and availability of healthcare services at the federal and provincial level.

The above issues and related questions have been described and analysed in three separate sections. The first section describes the different roles of the federal, provincial and territorial governments in the healthcare system; the second section describes the birth of the Medicare and inception of the CHA of 1984 and further elaborates the criteria and requirements under the CHA; and the third section shows the results and findings of the CHA, its coverage and importance in the present scenario by using the regression model. The use of regression model is justified in this analysis because the study aims at identifying the causal relationship between the number of registered persons in the healthcare system and various other policy variables taken as an independent variable (the number of hospitals, the number of doctors, etc.). The analysis tries to inspect closely the factors which are prime contributors to the rising number of registered persons in the

Canada healthcare system despite a growing preference for the private healthcare system instead of public healthcare facilities.

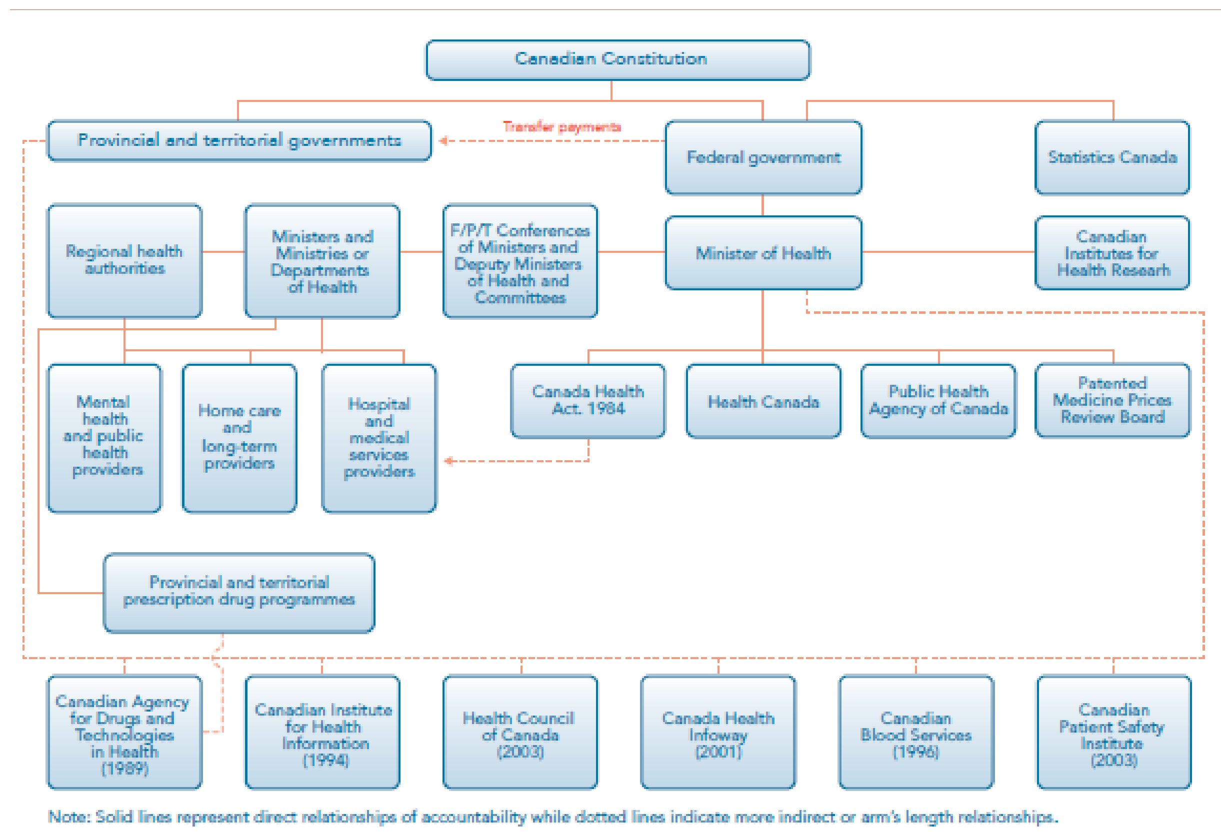
The Roles of Different Levels of Government in Health System

The Canadian health system as shown in the figure 3.1 is a complex mix of policies, legislations and relationships. Health is not just a single subject matter under the Canadian Constitution, but is rather spread among several heads of powers – both federal and provincial (Tigerstrom 2011). Peter Hogg (1988) rightly said:

> Health is not a single matter assigned by the Canadian constitution exclusively to one level of government. Like inflation and the environment, health is an ‘amorphous topic' which is distributed to the federal parliament or the provincial legislatures depending on the purpose and the effect of the particular health measure at issue (Leeson 2004).

The organisation of Canada's healthcare system is largely determined by the Canadian Constitution, in which roles and responsibilities are divided between the federal, provincial and territorial governments. “The provincial and territorial governments have been assigned the responsibility of delivering health services. Healthcare is mainly a provincial responsibility, Canada’s ten provinces and three territories are responsible for providing Canadians with coverage for medically necessary hospital and physician services as well as access to other health facilities” (Marchildon 2013).

Figure 3.1 :Organisation of the Health System in Canada



Source: Marchildon(2013)

Under the British North America Act (BNA) 1867, “the provinces were responsible for establishing, maintaining and managing hospitals, asylums, charities and charitable institutions and the federal government was given jurisdiction over marine hospitals and quarantine (Health Canada 2011).”The roles of the provincial and territorial governments in healthcare include:

- administration of their health insurance plans;
- planning and funding of care in hospitals and other health facilities;
- services provided by doctors and other health professionals;
- planning and implementation of health promotion and public health initiatives; and
- negotiation of fee schedules with health professionals.

In addition to the above mentioned services and assistance to the citizens, “most provincial and territorial governments also offer additional funds to certain groups (low

income residents and seniors) such as drugs prescribed outside hospitals, ambulance costs, and hearing, vision and dental care that are not covered under the CHA."These additional benefits for certain groups are largely financed privately. Individuals and families who do not qualify for publicly funded coverage may pay these costs directly (out-of-pocket expenses), which can either be covered under an employment-based group insurance plan or through private insurance.

The federal government is also responsible for "some delivery of services for certain groups of people. These groups include: First Nations people living on reserves, Inuit, serving members of the Canadian Forces, eligible veterans, inmates in federal penitentiaries and some groups of refugee claimants (Health Canada 2011)." The federal government roles in healthcare include "setting and administering national principles under the CHA, financial support to the provinces and the territories. The federal government provides cash and tax transfers to the provinces and territories in support of health through the Canada Health Transfer (CHT). The most important federal power related to health is its "spending power" which is discussed in detail in Chapter 5. This refers to the constitutional right of a government to spend money and also represents a key for the federal government as a mean of exercising authority over the provinces and the way in which healthcare policies may be influenced at implementing stage.

The federal government is also "responsible for food and drug safety, pharmaceutical patents and price regulation of branded drugs. In addition, the federal government also has important responsibilities in the domains of public health, health research and health data collection (Marchildon 2013)."Furthermore, "the Peace, Order and Good Government, known as "POGG" clause, grants the federal government the power to legislate in times of a national health emergency (Butler and Tiedemann 2013)."

Although the provinces are responsible for the delivery of healthcare, the federal government provides partial funding of healthcare to ensure that national healthcare policy exists. Total expenditures on healthcare have increased over time, which is mentioned in the previous chapter. Technology, demographics and evolving patient expectations have also influenced the healthcare system (Kenny and Chafe).

Birth of Medicare and the Canada Health Act (CHA) 1984

Public insurance for hospital and medical care is known as Medicare. The criteria of universal coverage and public administration meant the demise of private insurance for insured services and the emergence of each provincial government as a single-party payer (Heiber and R. Deber 1987).

In 1984, Tommy Douglas, known as the father of Canadian Medicare, encouraged the Canadian population to defend the universal healthcare coverage for which he so vigorously fought in the 1960s. Under his leadership, Saskatchewan initiated a plan for public funding of all medically necessary hospital services in 1947. In 1948, the federal government offered health grants to the provinces to help pay for hospital services. This was followed by the Hospital Insurance and Diagnostic Services Act in 1957, through which the federal government offered to share the cost of hospital services (Harvey 2014).

"Saskatchewan also originated public funding for all medically necessary physician services. This development gave rise to the concern that this arrangement would threaten physician autonomy and might damage the physician-patient relationship. In 1962, the year in which Saskatchewan first introduced coverage, doctors in the province responded by striking. The strike was brought to an end after 23 days."

In 1966,the Medical Care Act was passed by the federal government, and by the early 1970s, all provinces had adopted this plan that provided for provincial funding, with federal government sharing of expenses (David C. Hawkes and Bruce G. Pollard). The sharing of healthcare costs on a 50:50 basis was accepted by the most provinces. In 1966, the Canada Assistance Plan (CAP) was introduced, creating a cost-sharing arrangement for social assistance programmes (Department of Finance Canada).

The Lalonde Report of 1974 provided a review of the healthcare system and outlined a new paradigm for the public provision of healthcare. Specifically, the report called for the government to expand its role beyond simple healthcare provider; a focus on health

promotion and encouragement of individual responsibility for healthcare was recommended (Heather and MacDougall 2007).

The CHA of 1984 replaced the Hospital Insurance and Diagnostic Services Act of 1957 largely because of the shift from a system of 50:50 federal-provincial cost-sharing to a system of block funding established by Ottawa in 1977. By 1979, Ottawa determined that 17.9 per cent of doctors in Ontario had opted out of Medicare and were engaged in extra-billing their patients. One needs to understand how to address the above issue because it was constitutionally challenged to control the provincial institutions and health professionals' behaviour. It took almost three years to find a way with Bill C-3, which became the CHA of 1984.

The CHA embraces the four principles (public administration, comprehensiveness, universality, and portability) of the Hospital Insurance and Diagnostic Services Act of 1957 and added a fifth element of 'accessibility' (Fierlbeck 2011).

This act brought together all the previous measures of the public hospital and physician service insurance under a unified piece of legislation. "Canada's healthcare system has evolved to provide public funding for all medically necessary hospital and physician services." The CHA of 1984 as:

> The Canada Health Act is Canada's federal legislation for publicly funded health care insurance. The Act sets out the primary objective of Canadian health care policy, which is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers"(Health Canada).

In 1979, at the request of the federal government,

> Justice Emmett Hall undertook a review of the state of health services in Canada. In his report, he affirmed that healthcare services in Canada ranked among the best in the world, but warned that extra-billing by doctors and user fees levied by hospitals were creating a two-tiered system that threatened the universal accessibility of care. This report, and the national debate it generated, led to the enactment of the CHA in 1984.

(a) Requirements of the CHA

The Act establishes criteria and conditions related to insured[1] health services and extends[2] healthcare services that the provinces and territories must fulfil to receive the full federal cash contribution under the Canada Health Transfer (CHT) (Canada Health Act Annual Report 2012-2013). Provinces and territories must adhere to the CHA or they face the risk of losing federal transfers (Verma and Petersen et al. 2014)

The CHA contains nine requirements that "the provinces and territories must fulfil in order to qualify for the full amount of their cash entitlement under the CHT." They are:

- Five programme criteria, that apply only to insured health services;
- Two conditions, that apply to insured health services and extended healthcare services; and
- Extra-billing and user charge provisions that apply only to insured health services.

The Five Criteria are as follows:

1. Public Administration (Section 8)

> The public administration criterion requires the provincial and territorial healthcare insurance plans to be administered and operated on a non-profit basis by a public authority, which is accountable to the provincial or territorial governments for decision-making on benefit levels and services and whose records and accounts are publicly audited (CHA).

2. Comprehensiveness (Section 9)

> The comprehensiveness criterion of the Act requires that the healthcare insurance plan of a province or territory must cover all insured health services provided by the hospitals, physicians or dentists. The Act neither mentions the quantity of services to be provided nor can give a detailed list of what services will be insured; provincial governments define these. Thus, the range of insured services may vary among provinces and from one year to the next (Madore 2005; and CHA).

[1] Insured health services are medically necessary hospital, physician and surgical-dental services (performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedure) provided to insured persons.

[2] Extended healthcare services, as defined in the Act, are certain aspects of a long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

3. Universality (Section 10)

Under the universality criterion, all insured residents of a province or territory must be entitled to the insured health services provided by the provincial or territorial healthcare insurance plan on a uniform terms and conditions. Provinces and territories generally require that residents register with the plan to establish a claim (CHA).

4. Portability (Section 11)

Residents moving from one province or territory to another must continue to be covered for insured health services by the "home" jurisdiction during any waiting period (up to three months) imposed by the new province or territory of residence. It is the responsibility of residents to inform their province or territory's healthcare insurance plan that they are leaving and to register with the healthcare insurance plan of their new province or territory. Residents who are temporarily absent from their home province or territory or from Canada must continue to be covered for insured health services during their absence. If insured persons are temporarily absent in another province or territory, the portability criterion requires that insured services be paid at the host province's rate (CHA).

5. Accessibility (Section 12)

The fifth criterion is to ensure that insured persons in a province or territory have reasonable access to insured hospitals, medical and surgical-dental services on uniform terms and conditions, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances). Reasonable access in terms of physical availability of medically necessary services has been interpreted under the CHA using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health services at the setting "where" the services are provided and as the services are "available" in that setting. The healthcare insurance plans of the province or territory must provide:

(i) reasonable compensation to physicians and dentists for all the insured health services they provide; and
(ii) payment to hospitals to cover the cost of insured health services.

Table 3.1: Five Criteria of CHA

Criteria	Each provincial healthcare insurance plan must:
Public Administration (Section 8)	Be administered and operated on a non-profit making basis by a public authority
Comprehensiveness (Section 9)	It requires that the healthcare insurance plan of a province or territory must cover all insured health services provided by the hospitals, physicians or dentists (surgical-dental services that require a hospital setting)
Universality (Section 10)	Ensure entitlement to all insured health services on uniform terms and conditions
Portability (Section 11)	Coverage must be maintained when a resident moves within Canada or travels outside the country. Out-of-country coverage is limited to payment at existing provincial rates.
Accessibility (Section 12)	There can be no financial barriers to receiving medically necessary hospital and physician services. Reasonable compensation for physicians and hospitals must be paid, and extra billing (beyond payments made by the provincial plans) is prohibited.

Source: Health Canada (2011) cited in Marchildon (2013)

The above table summarised the five criteria of the CHA. Thus, one needs to understand that under portability, citizens are eligible for coverage in all provinces, meaning that employees can follow job opportunities both within and between provinces, without losing their coverage and without restricting the flexibility of the labour force. Because residents are signed up to a provincial plan, they can access healthcare anywhere in the province. Public administration enables governments to distribute services more effectively and efficiently with stability. It also allows for public debate and planning. Under universality, everyone is covered, which is not only more democratic but also cheaper and more efficient. Accessibility to health services must be provided under uniform terms and conditions. It also includes reasonable compensation for all insured

services. As for comprehensiveness, the CHA does not extend much beyond medically necessary services provided by doctors and hospitals; it includes all services required within the confines (Armstrong and Hugh Armstrong 1999: 1202). These principles are essential funding criteria, which have come to represent the principles and values that supported Medicare policy for Canadians.

The CHA requires that "insured health services be provided to insured persons in a manner that is consistent with the criteria and conditions set out in the Act, not all Canadian residents or health services fall under the scope of the Act."

Excluded Services

> A number of services provided by the hospitals and physicians are not considered medically necessary and thus are not insured under the provincial and territorial health insurance legislation. Uninsured hospital services for which patients may be charged include preferred hospital accommodation unless prescribed by a physician or when standard ward level accommodation is unavailable, private duty nursing services, and the provision of telephones and televisions. Uninsured physician services for which patients may be charged include telephone advice, the provision of medical certificates required for work, school, insurance purposes and fitness clubs, testimony in court, and cosmetic services.

Excluded Persons

> The CHA definition of "insured person" excludes members of the Canadian Forces and persons serving a term of imprisonment in a federal penitentiary. The Government of Canada provides coverage to these groups through separate federal programmes. The exclusion of these persons from the insured health service coverage predates the adoption of the Act and is not intended to constitute differences in access to publicly insured healthcare.
>
> The Conditions:
> 1. Information (Section 13 (a))
> The provincial and territorial governments are required to provide information to the federal Minister of Health as prescribed by regulations under the Act.
>
> 2. Recognition (Section 13 (b))
> The provincial and territorial governments are required to recognise the federal financial contributions towards both insured and extended healthcare services.

Extra-billing (Section 18):

> Under the Act, extra-billing is defined as the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist (i.e., a dentist providing insured surgical-dental services in a hospital setting) in addition to any amount paid or to be paid for that service by the healthcare insurance plan of a province or territory. For example, if a physician was to charge a patient any amount for an office visit that is insured by the provincial or territorial health insurance plan, the amount charged would constitute extra-billing. Extra-billing is seen as a barrier or impediment for people seeking medical care and is therefore also contrary to the accessibility criterion.

User Charges (section 19):

> The Act defines user charges as any charge for an insured health service, other than extra-billing. For example, if patients were charged a facility fee for the non-physician (i.e., hospital) services provided in conjunction with a physician service that is insured under the provincial health insurance plan at a clinic, that fee would be considered a user charge. User charges are not permitted under the Act because, as is the case with extra-billing, they constitute a barrier or an impediment to access.

(a) Other Elements of the Act

Regulations (Section 22):
Section 22 of the CHA permits the federal government to make regulations for administering the Act in the following areas:

- defining the services included in the Act's definition of "extended health care services," e.g., nursing home care or home care;
- prescribing which services are excluded from hospital services;
- prescribing the types of information that the federal Minister of Health may reasonably require as well as the format and submission deadline for the information; and
- prescribing how provinces and territories are required to recognise the CHT in their documents, advertising or promotional materials(CHA Annual Report 2013-2014).

Dispute Avoidance and Resolution Process:

There is also a clause in this Act regarding the dispute and the resolution process. In April 2002, federal Minister of Health A. Anne McLellan outlined, "in a letter to her provincial and territorial counterparts, the CHA Dispute Avoidance and Resolution process, which was agreed to by the provinces and territories, except Quebec. The process meets federal and provincial or territorial interests of avoiding disputes related to

the interpretation of the principles of the Act and, when this is not possible, resolving disputes in a fair, transparent and timely manner."

Thus,the process includes the dispute avoidance activities of government-to-government information exchange, discussions, and clarification of issues as they arise. Where dispute avoidance activities prove unsuccessful, dispute resolution activities may be initiated, beginning with government-to-government fact-finding and negotiations. If these are unsuccessful, either minister of health involved may refer the issues to a third-party panel to undertake fact-finding and provide advice and recommendations. The federal Minister of Health has the final authority to interpret and enforce the CHA. In deciding whether to invoke the non-compliance provisions of the Act, the Minister will take the panel's report into consideration.

Penalty Provisions of the CHA

Mandatory Penalty Provisions:
Under the Act, "the provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments under the CHT."

Discretionary Penalty Provisions:
Noncompliance with one of the five criteria or two conditions of the Act is subject to a discretionary penalty. The amount of any deduction from federal transfer payments under the CHT is based on the level of the non-compliance. "The CHA sets out a consultation process that must be undertaken with the province or territory before discretionary penalties can be levied. To date, the discretionary penalty provisions of the Act have not been applied."

Table 3.2: History of Deductions and Refunds under the CHA

DEDUCTIONS AND REFUNDS TO CHST/CHT CASH CONTRIBUTIONS IN ACCORDANCE WITH THE CANADA HEALTH ACT SINCE 1994–1995 (IN DOLLARS)

Province/ Territory	1994–1995	1995–1996	1996–1997	1997–1998	1998–1999	1999–2000	2000–2001	2001–2002	2002–2003	2003–2004	2004–2005
NL	0	46,000	96,000	128,000	53,000	(42,570)	0	0	0	0	1,100
PEI	0	0	0	0	0	0	0	0	0	0	0
NS	0	32,000	72,000	57,000	38,950	61,110	57,804	35,100	11,052	7,119	5,463
NB	0	0	0	0	0	0	0	0	0	0	0
QC	0	0	0	0	0	0	0	0	0	0	0
ON	0	0	0	0	0	0	0	0	0	0	0
MB	0	269,000	588,000	586,000	612,000	0	0	300,201	0	0	0
SK	0	0	0	0	0	0	0	0	0	0	0
AB	0	2,319,000	1,266,000	0	0	0	0	0	0	0	0
BC	1,982,000	43,000	0	0	0	0	0	0	4,610	126,775	72,464
YK	0	0	0	0	0	0	0	0	0	0	0
NWT	0	0	0	0	0	0	0	0	0	0	0
NU	0	0	0	0	0	0	0	0	0	0	0
Total	1,982,000	2,709,000	2,022,000	771,000	703,950	18,540	57,804	335,301	15,662	133,894	79,027

2005–2006	2006–2007	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012	2012–2013	2013–2014	2014–2015	Total
0	0	0	0	0	3,577	58,679	50,758	(10,765)	0	**383,779**
0	0	0	0	0	0	0	0	0	0	**0**
(8,121)	9,460	0	0	0	0	0	0	0	0	**378,937**
0	0	0	0	0	0	0	0	0	0	**0**
0	0	0	0	0	0	0	0	0	0	**0**
0	0	0	0	0	0	0	0	0	0	**0**
0	0	0	0	0	0	0	0	0	0	**2,355,201**
0	0	0	0	0	0	0	0	0	0	**0**
0	0	0	0	0	0	0	0	0	0	**3,585,000**
29,019	114,850	42,113	66,195	73,925	75,136	33,219	280,019	224,568	241,637	**3,409,530**
0	0	0	0	0	0	0	0	0	0	**0**
0	0	0	0	0	0	0	0	0	0	**0**
0	0	0	0	0	0	0	0	0	0	**0**
20,898	124,310	42,113	66,195	73,925	78,713	91,898	330,777	213,803	241,637	**10,112,447**

Note: Understanding This Table

- To date, most deductions have been made on the basis of statements of actual extra-billing and user charges, meaning that they are made two years after the extra-billing and user charges occurred.
- In instances where provinces and territories estimate anticipated amounts of extra-billing and user charges for the upcoming year, a deduction is taken in respect of those charges in the fiscal year for which they are estimated.
- In addition to forming the basis for most deductions under the Act, the statements of actual extra-billing and user charges provide an opportunity to reconcile any estimated charges with those that actually occurred. These reconciliations form the basis for further deductions or refunds to provincial and territorial cash transfers.
- Numbers in parentheses represent refunds to the province or territory.

Source: CHA Annual Report 2014-2015.

The above table shows deductions and refunds to the Canada Health and Social Transfers (CHST)/CHT since 1994-1995 to 2014-2015. On 31 March 1987, the federal government decided that all provinces, which had extra-billing and user charges, had taken proper steps in this matter. By June 1987, a total of C$244,732,000 in deductions was refunded to New Brunswick (C$6,886,000), Quebec ($14,032,000), Ontario (C$106,656,000), Manitoba (C$1,270,000), Saskatchewan (C$2,107,000), Alberta ($29,032,000) and British Columbia (C$84,749,000). After three years of the CHA of 1984, passed

deductions were refunded to provinces and territories as mentioned above. The penalties under the CHA did not reoccur until the fiscal year 1994–1995 (CHA Annual Report 2014-2015).

British Columbia

In the early 1990s, "several doctors opted out of the provincial health insurance plan and began billing their patients directly. Some of these doctors billed their patients at a rate greater than the amount the patients could recover from the provincial health insurance plan. This higher amount constituted extra-billing under the CHA."

Deductions began in May 1994, relating to the fiscal year 1992–1993, and continued until extra-billing by physicians was banned when changes to British Columbia's Medicare Protection Act came into effect in September 1995. In total, C$2,025,000 was deducted from British Columbia's cash contribution for extra-billing that occurred in the province between 1992–1993 and 1995–1996. These deductions were non-refundable (CHA Annual Report 2014-2015).

Alberta

From November 1995 to June 1996, total deductions of C$3,585,000 were made to Alberta's cash contribution in respect of facility fees charged at clinics providing surgical and abortion services. On 1 October 1996, Alberta prohibited private surgical clinics from charging patients a facility fee for medically necessary services for which the physician fee was billed to the provincial health insurance plan (CHA Annual Report 2014-2015).

Nova Scotia

The total deductions of C$372,135 were made to Nova Scotia's CHST cash contribution for its failure to cover facility charges to patients while paying the physician fee. A final deduction of $5,463 was taken from the March 2005 Canada Health Transfer (CHT) payment to Nova Scotia as a reconciliation of deductions that had already been taken for 2002–2003.A one-time positive adjustment in the amount of $8,121 was made to Nova Scotia's March 2006 CHT payment to reconcile amounts actually charged in respect of

extra-billing and user charges with the penalties that had already been levied based on provincial estimates reported for fiscal 2003–2004 (CHA Annual Report 2014-2015).

Deductions for each year are detailed in a table following this passage. Since March 2011, deduction amount C$102,249 have been taken from CHT payments to Newfoundland and Labrador for extra-billing and user charges, based on charges reported by the province to Health Canada. Since these charges resulted from services provided by an opted-out dental surgeon who has since left the province, Health Canada considers this matter resolved.

Since the passage of the CHA, from April 1984 to March 2013, deductions total C$10,112,447 have been taken from transfer payments in respect of the extra-billing and user charge provisions of the CHA. This amount excludes deductions of total C$244,732,000 that were made between 1984 and 1987 and subsequently refunded to the provinces when extra-billing and user charges were eliminated as shown in the table.

Results and Findings: Using Regression Model

Benefit of Regression over other Statistical Packages

Regression provides a wide variety of statistical and graphical techniques, and is highly extensible. The Regression model provides an open source route to participation in that activity. Unlike the other statistical tools, regression analysis takes into account the risks of making assumptions and easily addresses the most complicated of problems due to its flexibility. It considers the significance of each variable and what effect they have on each other, while solving the trickiest of situations.

The main benefits of regression analysis that make it a popular tool are among the other statistical packages are:

- can handle multiple co-related predictor variables
- studies the effect of one predictor variable on a dependent variable
- higher-order terms can be used for modelling and data analysis
- an effective data handling and storage facility, and
- graphical facilities for data analysis and display either on-screen or on hardcopy.

The regression analysis is used for determining whether changes in the policy variables like the number of hospitals, the numbers of doctors, and province expenditure on the healthcare system have a statistically significant impact on the number of registered persons in the Canadian healthcare system. This analysis will help in identifying as well as measuring the efficacy of the Canadian healthcare system constituted under the CHA. This analysis is used for quantitatively identifying the impact of changes in the CHA on the healthcare system. Descriptive analysis is used mainly for identifying trends in the variables, whereas regression provides a larger scope of in-depth analysis and interdependence among variables. The time period chosen for the analysis is 1999 to 2014 to clearly depict the impact of changes in the CHA which was initiated in 1999-2000 and further modified in the year 2004-05 through the bifurcation of CHST into CHT and Canada Social Transfer (CST). As social policies show impact with longer gestation periods, the data frame is expanded to the year 2014-15.

A regression model is a representation/description of reality. A regression model specifies how a quantitative variable (Y) is related to other variables (Xs), with certain assumptions (Chauhan 2014). The results generated show trends as confirmed by prior expectations and existing literature. Regression results have been shown in the following table and it includes the standard error value and significance of variables included in the regression model. There are multiple benefits of using regression analysis. They are as follows:

1. It indicates the significant relationships between the dependent variable and independent variable. The independent variable is a cause variable that produces an effect or results on a dependent variable in a causal hypothesis. Causal hypothesis is a statement of a causal explanation or proposition that has at least one independent and one dependent variable, and has yet to be empirically tested.
2. It indicates the strength of the impact of multiple independent variables on a dependent variable. The dependent variable is the effect or result variable that is caused by an independent variable in a causal hypothesis (Neuman 2013).

Regression analysis is a form of predictive modelling technique which investigates the relationship between a dependent (target) and independent variable (s) (predictor). The study uses a generalised linear model to analyse the nature and direction of a relationship between dependent and independent variables. In this analysis, the number of registered persons under the CHA is taken as a dependent variable to analyse the effect of independent variable on the same. The upward movement in the number of registered persons in any province or state is taken as the proxy for the effectiveness of health services of that particular region. The high quality services provided by states attract more people to be a part of the system to avail its benefits and the same trend is visible in the Canada health system also. The analysis is undertaken for year-wise and provinces- and territories-wise comparison of dependent and independent variables, mainly because state-wise differences in the quality of healthcare services are prevalent in the Canadian economy, and secondly such analysis can be used to derive conclusions about the long-term performance of the CHA. The registered persons, which are a part of the CHA or coverage from 1999 to 2015, are taken as the dependent variable of regression analysis. The status of registered persons taken as a dependent variable, which is regressed on independent variables like insured hospital services, both public and private, insured physician services, insured surgical-dental services, and the CHST.

Data Source

The data for the analysis is sourced from the annual reports of Canadian Government as provided on performance, finance and expenditure on the nation's healthcare system. These reports contain statistical information related to insured health services and other related variables as submitted by all provinces and territories (except Quebec province). The data set includes following provinces that are: Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario, Prince Edward Island, Quebec, and Saskatchewan. The territorial governments are Nunavut, Yukon, and the Northwest Territories. The data for dependent and independent variables is also sourced from the aforementioned report which is as follows:

- Registered Person: Registered persons are the number of residents registered with the healthcare insurance plans of each province or territory."
- Insured Hospital Services within the own province or territory: The data in this category is related to the provision of insured hospital services to residents of each province or territory."
- Insured Physician Services within the own province or territory: The data in this category is related to the provision of insured physician services to residents in each province or territory."
- Insured Surgical-Dental Services within own province or territory: The data in this category is related to the provision of insured surgical-dental services to residents in each province or territory."
- The CHT originally combined with the CST is a programme known as the CHST. It was made independent from the CHST programme on 1 April 2004 to allow for greater accountability and transparency for federal health funding.

Hypothesis: CHST/CHT has no impact on a number of registered persons in Canada. The state and year-wise analysis shown in the Table 3.3.

So our model is following form of the general linear model (GLM)

$Y = \alpha + ß1X1 + ß2X2 + ß3X3 + ß4X4 + ß5X5 + ß6X6 + \epsilon$

Or to be more precise

Where Yi represents the dependent variable, in this case, it is taken to be registered persons under the CHA or coverage.

α is the intercept term,

ß's are the coefficient of quantitative variables,

The present data covers nine provinces and three territories. The data covers almost two decades' period starting from 1999-2000 to 2014-2015. The regression undertakes year-wise and state-wise (provinces and territories) analysis. The main aim is to study the relationship between registered persons of the CHA/coverage and the CHST over this entire period.

Regression Results

As per the analysis, the null hypothesis (a hypothesis that states there is no significant effect of an independent variable on the dependent variable) stands rejected. So, the CHST has a significant impact on the number of registered persons under the CHA or coverage.

Regression results are presented in the following table and it includes standard error, T value, P value and significance of variables included in the regression model.

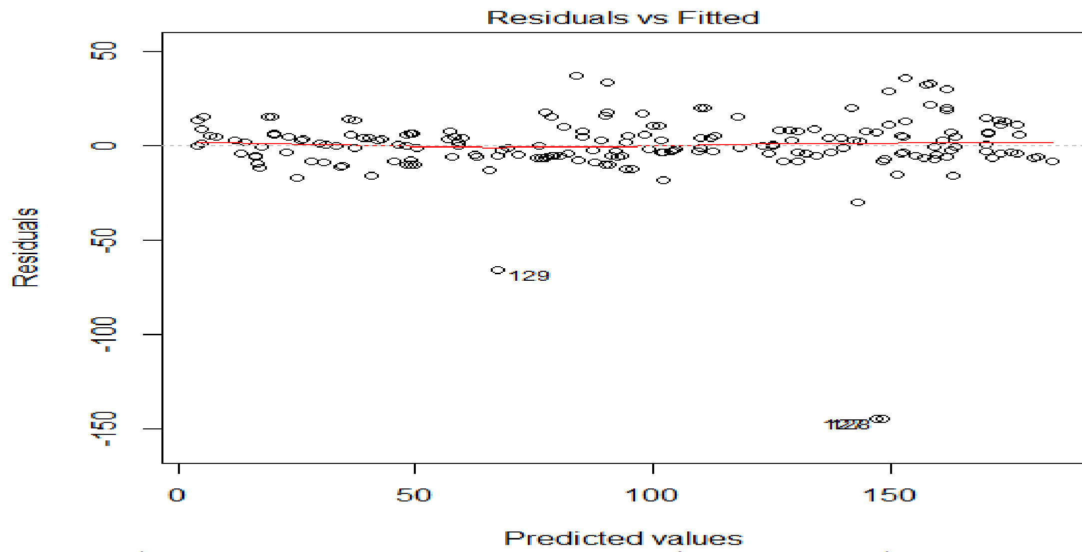
Table 3.3: Regression Results

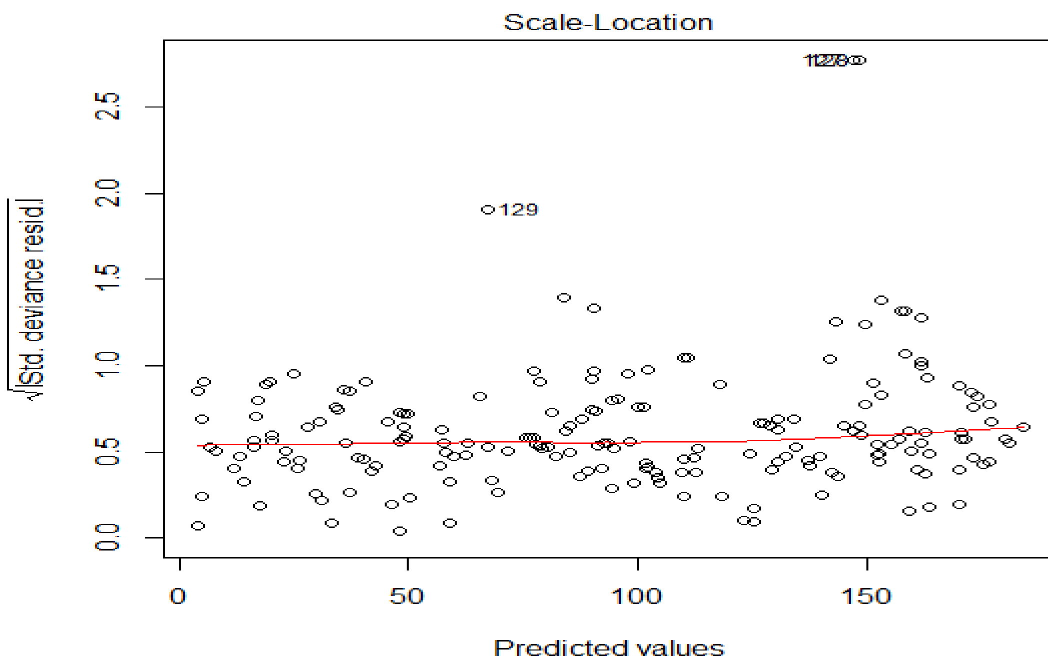
Regression Results and Findings

```
glm(formula = data$Registered_persons_number ~ data$CHST + data$Public_facilities_Number +
    data$State + data$Year + data$Private_for_profit_facilities_number +
    data$insured_Dentist_number + data$insured_physician_service)

Deviance Residuals:
     Min        1Q    Median        3Q       Max
-145.162    -5.416    -0.013     6.323    36.969

Coefficients:
                                       Estimate Std. Error t value Pr(>|t|)
(Intercept)                           38.739688  52.057099   0.744  0.45787
data$CHST                              0.162296   0.047322   3.430  0.00077 ***
data$Public_facilities_Number          0.006344   0.221854   0.029  0.97722
data$StateAlberta                     12.696206  22.319798   0.569  0.57027
data$StateBritish Columbia            42.624598  28.796930   1.480  0.14080
data$StateManitoba                   -39.169962  34.393788  -1.139  0.25647
data$StateN.North west territories    65.083189  46.790721   1.391  0.16619
data$StateNew Brunswick               98.131953  43.844026   2.238  0.02660 *
data$StateNewfoundland and Labrador   79.236004  44.429657   1.783  0.07643 .
data$StateNova Scotia                 92.426725  46.104668   2.005  0.04669 *
data$StateOntario                    -26.959822  26.305536  -1.025  0.30698
data$StatePrince Edward Island        -6.906823  50.798736  -0.136  0.89202
data$StateSaskatchewan               -51.068255  40.570706  -1.259  0.20997
data$StateTerritory Nunavut           17.547873  49.029626   0.358  0.72089
data$StateTerritory Yukon             26.545270  49.307969   0.538  0.59108
data$Year2000-2001                     7.957918   8.523826   0.934  0.35192
data$Year2001-2002                     7.697213   8.649901   0.890  0.37488
data$Year2002-2003                     8.190748   8.498703   0.964  0.33663
data$Year2003-2004                     8.861483   8.917314   0.994  0.32186
data$Year2004-2005                    17.980629   8.727493   2.060  0.04101 *
data$Year2005-2006                    13.590915   8.571384   1.586  0.11481
data$Year2006-2007                    15.593485   8.651716   1.802  0.07338 .
data$Year2007-2008                    16.171873   8.689267   1.861  0.06457 .
data$Year2008-2009                    17.863213   8.696916   2.054  0.04162 *
data$Year2009-2010                    17.797865   8.760726   2.032  0.04386 *
data$Year2010-2011                    20.739488   8.868467   2.339  0.02060 *
data$Year2011-2012                    21.533846   8.755197   2.460  0.01498 *
data$Year2012-2013                    23.266299   8.869016   2.623  0.00956 **
data$Year2013-2014                     8.852663   8.843266   1.001  0.31832
data$Year2014-2015                     9.435396   8.921144   1.058  0.29182
```


Residuals vs Fitted
Residuals
Predicted values
glm(data$Registered_persons_number ~ data$CHST + data$Public_facilities_Nu
129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Predicted values
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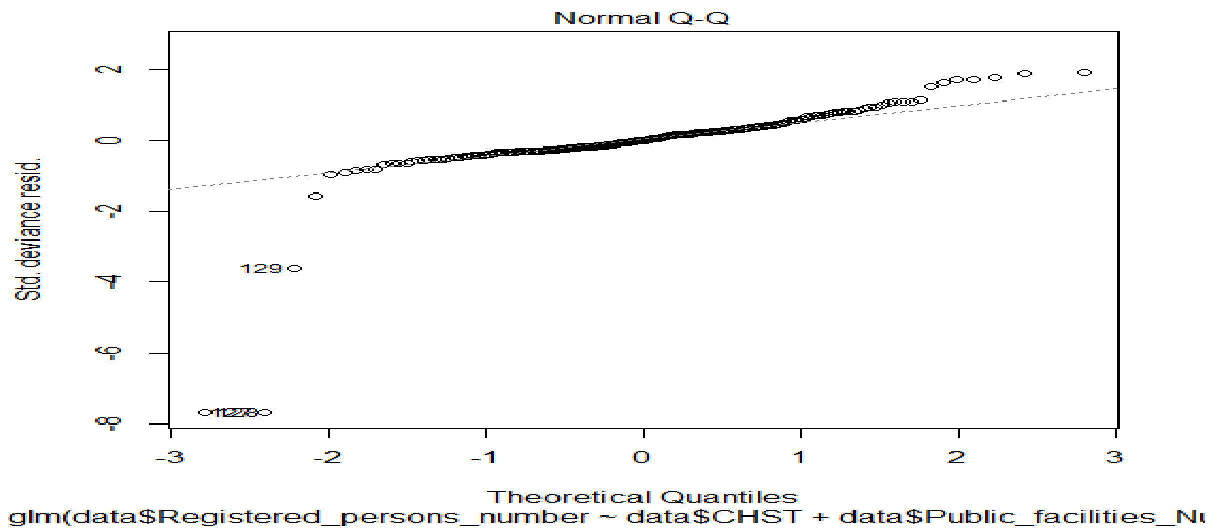
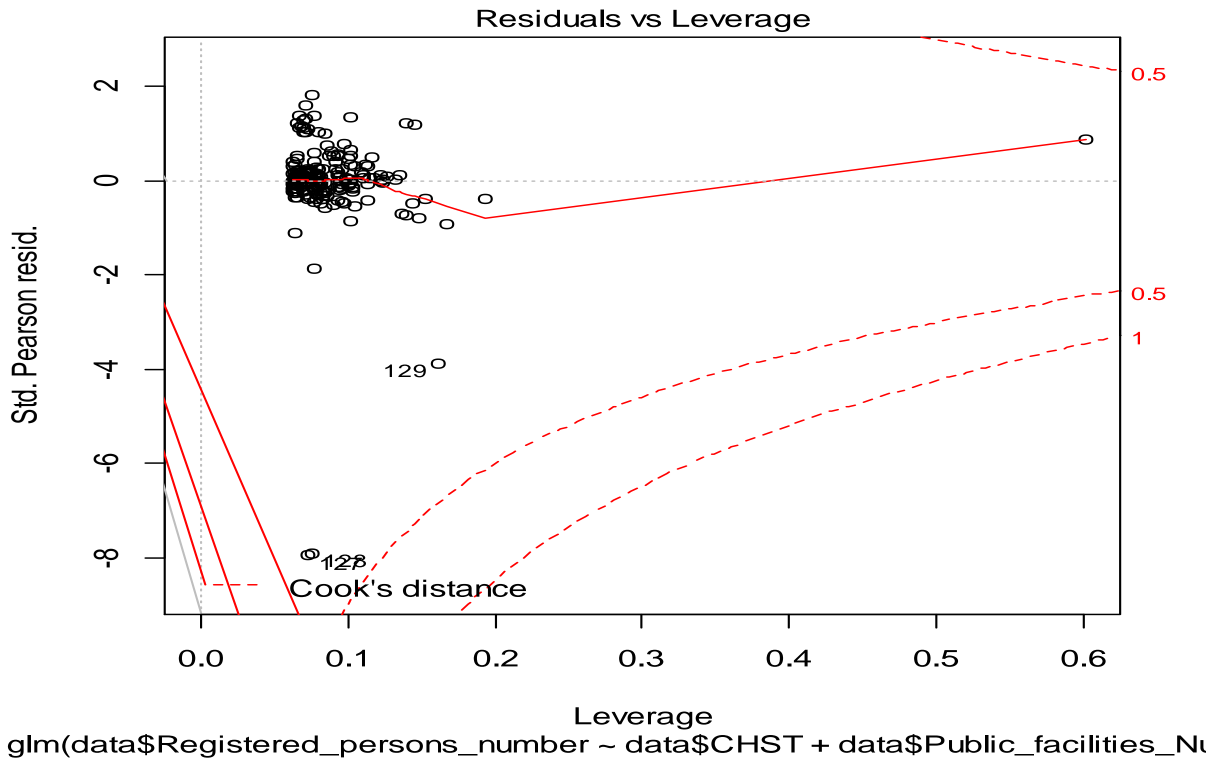

Normal Q-Q
Std. deviance resid.
Theoretical Quantiles
glm(data$Registered_persons_number ~ data$CHST + data$Public_facilities_Nu
129


Residuals vs Leverage
Std. Pearson resid.
Leverage
glm(data$Registered_persons_number ~ data$CHST + data$Public_facilities_Nu
Cook's distance
129
0.5
0.5
1

Validity of Results

To study the validity of regression results, various tests have been conducted to study whether an error term is normally distributed or not. As non-normality in the distribution of error terms means non-validity of regression results and such results cannot be used for checking the validity of a null hypothesis. In simple terms, error term should have zero mean and constant variance to produce valid regression results. One needs to understand that in this regression analysis the results are valid and robust in this case. The error term is normally distributed with a low error value.

The first diagram shows the residual errors plotted versus their fitted values. The residuals should be randomly distributed around the horizontal line representing a residual error of zero; that is, there should not be a distinct trend in the distribution of points. In our graph, the residuals show a pattern perhaps pointing towards a non-constant variance. But the mean of error terms turns out to be zero.

The third diagram is a standard Q-Q plot, it's a measure used for checking normalcy of residual terms. It requires the data distribution to follow Y=X line. So the values of data distribution should either lie on or near Y=X line which should suggest that the residual errors are normally distributed. Deviations from this would indicate possible departures from a normal distribution. In our analysis, the Q-Q Plot shows that the residuals do seem to follow approximately a normal distribution.

Finally, the last diagram shows each points leverage, which is a measure of its importance in determining the regression result as filled solid red line is strictly between two dotted lines so there are no outliers. The scale-location, the second diagram shows the square root of the standardised residuals (sort of a square root of relative error) as a function of the fitted values. Again, there should be no obvious trend in this plot which confirms that the variance is constant in error terms so results generated by this regression analysis will be valid.

The validity of our results is indicated by the fact that CHST is highly significant as the dependent variable affecting the number of registered persons under the CHA. The amount of CHST flowing to a province is positively related to the dependent variable (the number of registered persons in the healthcare act of Canada) and depicts that as funds disbursed/allocated to a province increases, it also brings improvement in the quality/effectiveness of the healthcare system of that province hence, a larger number of people register themselves to avail the services. It shows that over the years, the improved focus of Canada's economy on healthcare has brought positive dividends for people in particular and health sector in general.

As indicated by regression analysis, 2004 turns out to be a significant year for healthcare sector of the Canadian economy. The transfer of funds for healthcare increased significantly after 2004, as the CHST was bifurcated into CHT and CST in accordance with the Canadian Government's improved focus on healthcare in entire social sector expenditure.

During 2004, an agreement by First Ministers through ten year plans identified the areas within health sector where greater investments were essential to support and revive healthcare facilities as provided by the government. The federal government increased funding to provinces for healthcare by C$41.3 billion over the period of ten years. Most of this increase (C$35.3 billion) was included within the CHT, while a separate payment of C$5.5 billion was made to reduce waiting time and C$500 million was provided for medical equipment." Subsequent budget in 2007 again invested "an additional C$1 billion to help provinces and territories to introduce wait time guarantees, including initiatives delivered through Canada Health Infoway. Though the focus of Canada's policymakers has shifted towards the generation of jobs and higher economic growth as indicated in their legislations and public announcements from December 2011, the CHT will continue to grow at an annual rate of 6 per cent for an additional three years beyond 2013-2014 (CHA).

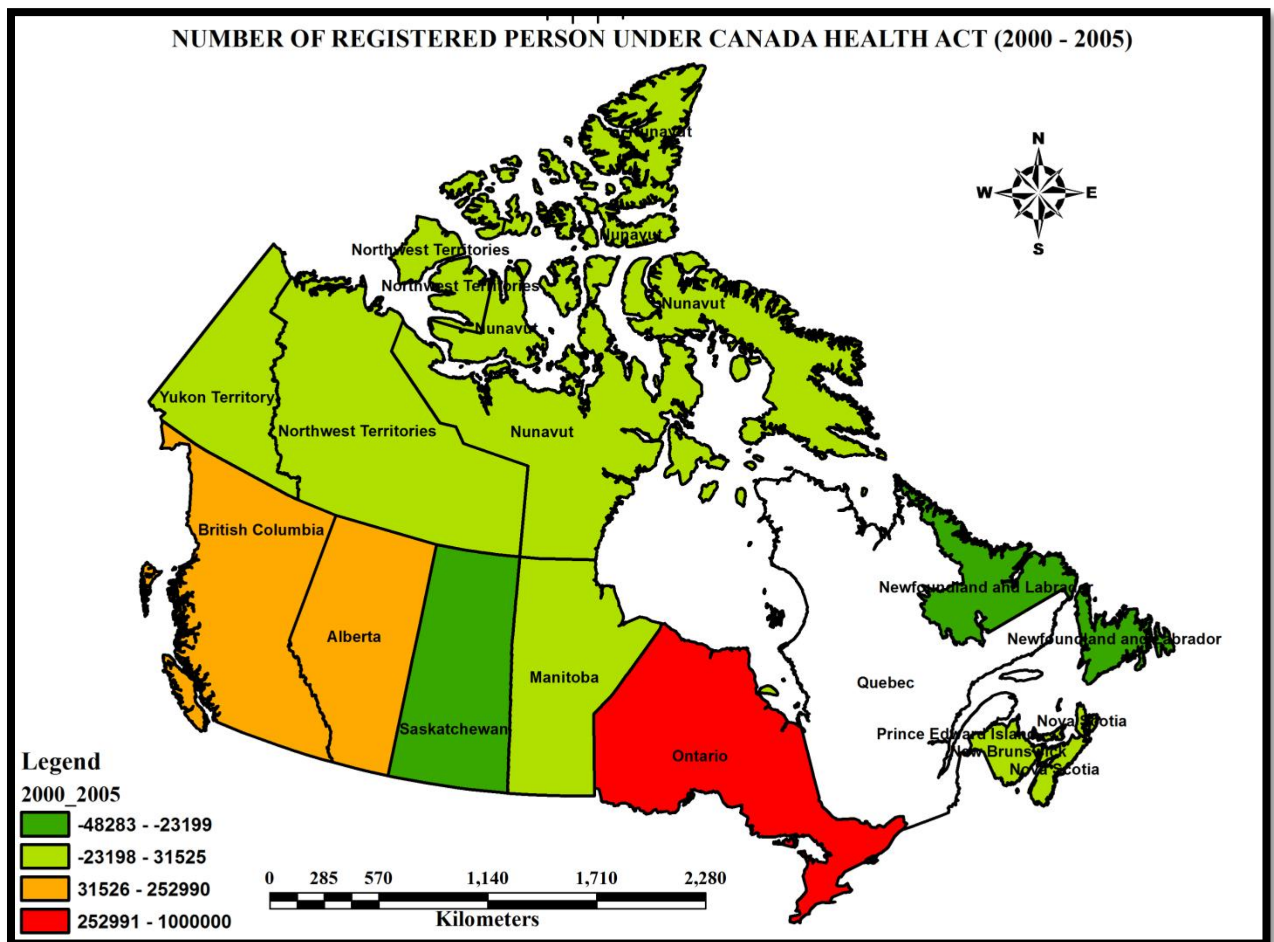
The state-wise analysis indicates that Newfoundland and Labrador, Nova Scotia and New Brunswick are performing best in attracting citizens towards government provided healthcare facility. It is not a coincidence that these states are also economically sound and stable. The Newfoundland and Labrador's capital and the largest city is St. John's, the epicentre of booming service industries, in which particularly the financial services are providing the largest share of province income. Nova Scotia and New Brunswick both are Maritime Provinces and the highest proportion of their incomes may be attributed to marine activities. These provinces are investing in social sector on a priority basis and it is indicated by our regression analysis that their performance is ahead of other provinces of the Canadian economy in economic and social sector. To conclude, it can be said that, as indicated by the data, the economic growth is followed by the growth of social sector in the context of the Canadian economy.

These three provinces, namely New Brunswick, Newfoundland and Nova Scotia, also permit private healthcare insurance for services that are also publicly insured. Thus, patients of 'opted-out' physicians in these provinces can substitute private for public healthcare coverage. Therefore, few people purchase private healthcare insurance (The Health of Canadians – The Federal Role Final Report, Volume Six: Recommendations for Reform, October 2002).

The number of registered persons in the healthcare system is increasing from 2000 onwards, which is shown in the following maps. One of the reasons for huge spending by the federal government is that people rely on the public insurance system.

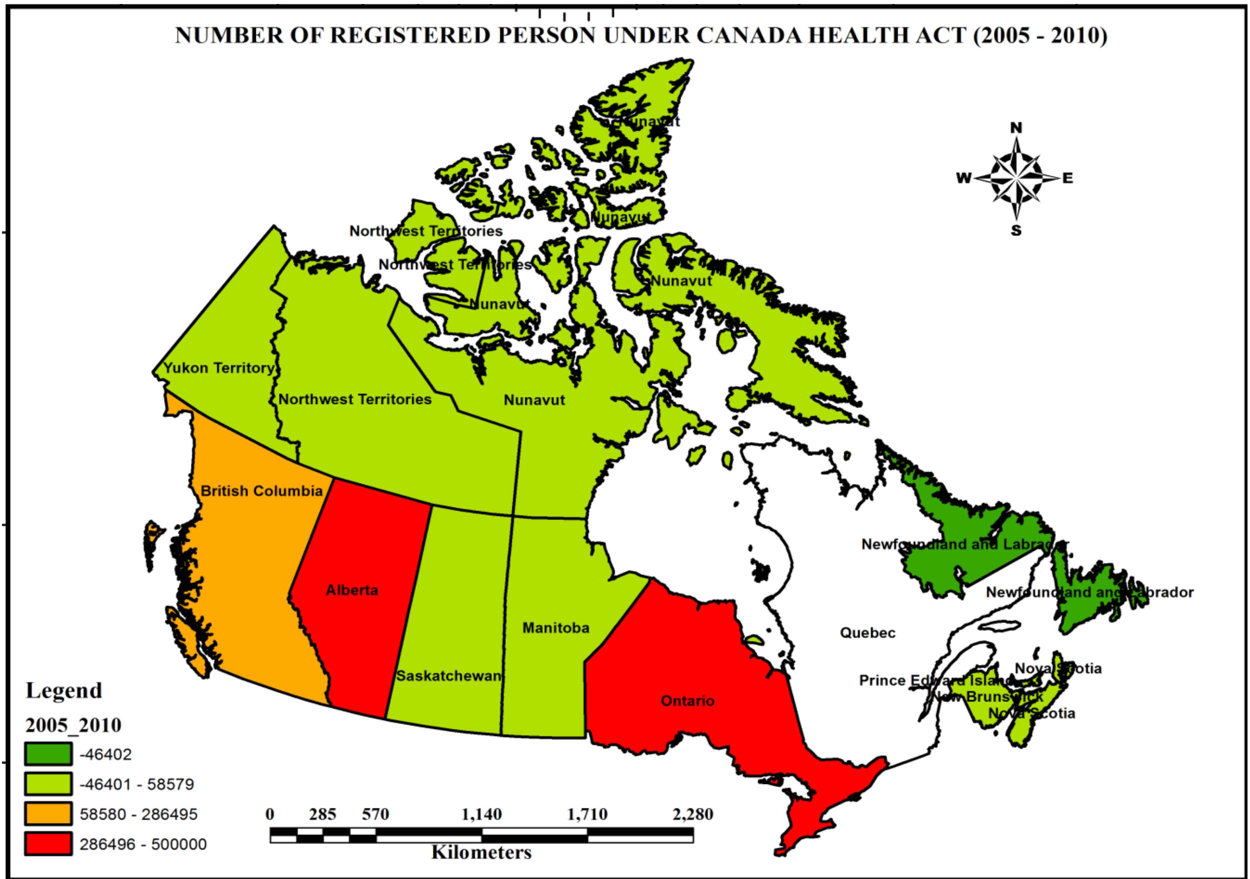
Map 3.1 shows the distribution of registered persons in the healthcare system of Canada; in a province-wise manner, it shows that provinces of Saskatchewan and Newfoundland and Labrador have lower concentration of registered persons, followed by Manitoba, Yukon, Northwest territories, Nunavut, Prince Edward Island, Nova Scotia and New Brunswick. The highest numbers of registered persons were in Ontario whereas Alberta and British Columbia ranked lower than Ontario in ranking of registered persons in the healthcare system.

Map 3.1: Registered Persons in the Healthcare System of Canada (2000-2005)



Source: Canada Health Act Annual Report (2000-2005)

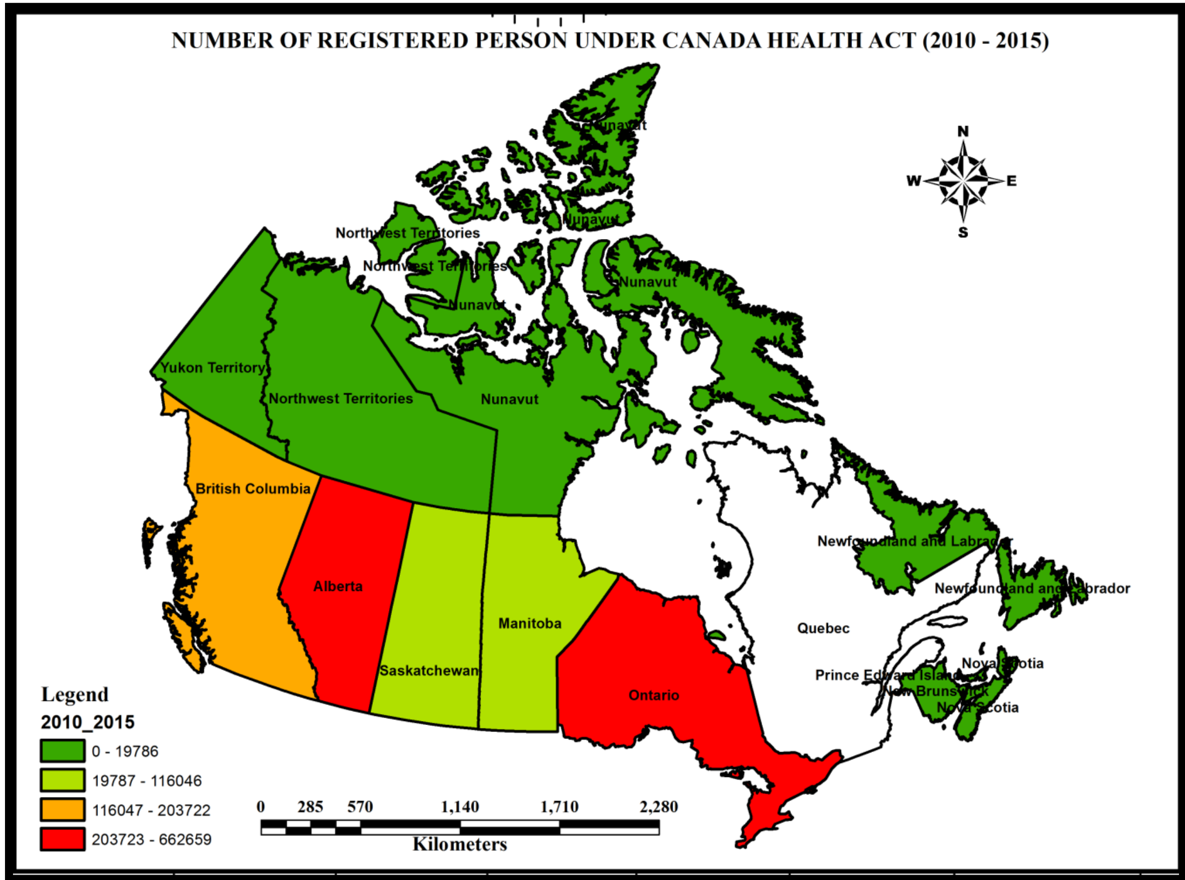
Map 3.2: Registered Persons in the Healthcare System of Canada (2005-2010)



Source: Canada Health Act Annual Report (2005-2010)

Map 3.2 depicts the change in the distribution of registered person over the period of 5 years. Newfoundland and Labrador retained their ranking in the distribution of registered persons, but Saskatchewan moved to higher concentration of registered persons. Alberta and Ontario now accounts for rank one and two in the registered number of persons under category of 286,496 to 500,000 people registered under the system.

Map 3.3: Registered Persons in the Healthcare System of Canada (2010-2015)



Source: : Canada Health Act Annual Report (2010-2015)

Map 3.3 shows drastic changes in the pattern of distribution of registered persons in the provinces of the Canadian economy. Alberta and Ontario retain two top most positions. In Alberta and Ontario, the number of registered persons is increasing. In 2000-2001, the number of registered persons in Alberta is 3,007,582 and in 2014-2015, it is 4,354,660; whereas in Ontario in 2000-2001, the number is 11,700,000 and in 2014-2015, it is 13,545,565. Most of the provinces now have moved to lowest registration category and it shows that the preference for the private provision of the health services in these provinces.

Conclusion

Despite the CHA, the three important elements needed for a better healthcare system in Canada are: (i) Cost containment, which is the capacity of a system to control expenditure in both public and private. (ii) Efficiency, that refers to the amount and quality of goods and services provided relatively to the amount of money spent. And, (iii) Equity, which is important in the provision of healthcare, depends on the values of the jurisdiction responsible for delivering healthcare. Equity becomes contentious in debates over the healthcare when it's perceived costs become too high. In this context, in Canada, the idea of 'one-tier' healthcare system becomes weak when long waiting lists for surgery, emergency services are seen to be a consequence of a public system. In Canada, there is a vast inequity between Canadians suffering different kinds of illnesses, "as all medically necessary hospital treatments are covered by public insurance in Canada, but often prescription drugs in many provinces are not" (Fierlbeck 2011).

Healthcare has undergone shifts from the era of welfarism to more market-oriented approaches. Access, quality, fairness and cost will always be contentious issues in the Canadian health system. The intergovernmental struggle over healthcare is structured on a Constitutional framework and superimposed with competing political dynamics. The period since 1999 is also the period of privatisation of health services in Canada which is mentioned in the next chapter. Many provinces are so frequently tempted towards greater privatisation of their healthcare systems, which entails higher costs and the costs are shifted from government to the private sphere. Provincial governments get tempted towards privatisation because it reduces their own expenditure on healthcare. One needs to understand that the CHA introduced the system of funding.

The healthcare challenges today are different from those that were there when the CHA of 1984 was designed. The regression and quantitative analysis have depicted how in some provinces the preference of the people has shifted from the public to private provision of health services. Though, the number of registered persons has increased in the period from 1999-2000 to 2014-15 but this increase is not uniform across all states. The major components responsible for this increase are mainly connected to

infrastructural facilities provided in the provinces like the number of doctors, the number of hospitals and the number of dentists in these provinces along with a corpus of funds received from the federal government specifically for the provision of healthcare services. The bifurcation of total federal transfers into health and social sector transfers has changed the way in which these services are funded at the provincial level. Now, the payments are primarily sourced from the provincial funds and to deal with the excess burden on the fiscal condition of the provinces, new methods are being evolved at the decentralised level. It has led to comparatively greater reliance on the private sector. The shortage of infrastructure in this sector has led to a long waiting durations for the patients, which has emerged as a major concern for provinces.

Regression analysis gives only a partial view of this disparity whereas the next Chapter examines inter temporal view of change in policies in the area of healthcare with the onset of SUFA and subsequent changes in the healthcare policy regime. The next Chapter further elaborates on inter provincial disparities in terms of provision of the healthcare in Canada.

CHAPTER IV

THE SOCIAL UNION FRAMEWORK AGREEMENT 1999

The last Chapter partially examined the province-wise differences in healthcare provision in Canada. This Chapter focuses primarily on the implementation of healthcare policy in different provinces and territories of Canada. Some special cases like Quebec are also discussed, which did not participate in the Social Union Framework Agreement (SUFA) and were out of the purview of uniform healthcare policy across Canada. The SUFA signifies a movement towards a more collaborative style of federalism in the field of healthcare.

The SUFA is important in understanding how intergovernmental relations (IGR) have been revitalised in the wake of changes introduced in intergovernmental relations (IGR) especially in the area of healthcare and ‘spending power’. The SUFA introduced the way in which flow of financial powers was determined from one tier of government to another in the years to come. This agreement hasn't only dwelt upon the horizontal flow of funds, but also analysed in depth the provinces specified issues and challenges faced by the Canadian healthcare system. Canadians want sustainable, affordable, high quality social programmes that respond to their health needs. They want governments to work cooperatively so as to achieve more. The SUFA is an important step in this direction (McLean 2000). In 1997, the Final Report of the National Forum on Health identified a “strong federal/provincial/territorial partnership” as a key principle for healthcare renewal. In its 1999 review of federal support for healthcare delivery, the Auditor General of Canada urged the federal government and the provinces to “build on the SUFA and work together to avoid and resolve disputes over the interpretation of the Canada Health Act.”

Despite the refusal of Quebec province to sign the SUFA, on 4 February 1999, the agreement signed between the federal, provincial and territorial governments marked an important step in the revitalisation of IGR. The agreement between the First Ministers was “intended to clarify the role of federal government regarding social programmes;

define the federal ‘spending powers’; and ensure greater accountability in terms of services to the public.”

The present Chapter is divided into four parts. The first section describes the making of SUFA. In the subsequent section, issues raised by the SUFA and the impact of non involvement of Quebec province in the SUFA are also examined. And the third section discusses the recommendations of three landmark reports [Mazankowski Report (2002), Kirby Report (2002) and Romanow Report (2002)] on the Canadian healthcare system, Health accords of 2003 and 2004, and the bifurcation of CHST 2005 and Quebec’s objection on privatisation in this context; the famous case the Chaoulli decision has been described in the last section of the Chapter.

The Making of SUFA

SUFA is an agreement between the federal, provincial (except Quebec) and territorial governments to sustain and improve Canada’s social policies and programmes. SUFA sets out extensive principles for the new era of social policy and cooperation in the areas of health, children, post-secondary education and other social programmes. So, one needs to understand that SUFA is a political agreement between the federal government, nine provincial and two territorial governments about improving the social union for Canadians. In particular, the agreement is aimed at enabling the Federal/Provincial/ Territorial governments to work together

> … and with Canadians, to strengthen our health care system, eliminate barriers to mobility for Canadians, involve Canadians in the development of social programmes, and strengthen partnership among governments (The Native Women’s Association of Canada 2002).

According to McLean (2000):

> The construction of the social union began in the period following the Second World War with the rapid expansion of government services to meet the basic social needs of Canadians. These programmes required large financial investments by the federal, provincial and territorial governments and committed both orders of government to the long-term maintenance of services that Canadians came to expect. A large part of the federal government’s commitment

> was to share the costs of some programmes through a system of financial transfers to the provinces and territories. The amount of the fiscal transfers was calculated by using formulas that were determined through a process of intergovernmental negotiations.

The tensions escalated when the federal government limited transfers to the provinces for their expenditures under the Canada Assistance Plan (CAP) in 1990 and tensions peaked in 1995 when the federal government replaced the existing system with the Canada Health and Social Transfer (CHST) and, at the same time, reduced its total transfers to the provinces and territories.

In this context, Facal (2005) argues that the Chrétien government was elected in 1993 and its 1994 budget was a 'business-as-usual' budget. But hostile reactions to it and the collapse of the Mexican economy led Jean Chrétien and, further, Paul Martin to aggressively tackle the federal deficit in the 1995 budget. Ottawa reviewed all spending programmes in its own areas of jurisdiction, but it also severely cut its transfer payments to the provinces.

> The replacement of earlier transfer mechanisms with the new CHST in the 1995 federal budget was accompanied by funding cuts of six billion dollars over two years for healthcare, social services and post-secondary education, which amounted to approximately 5% of total annual provincial spending. Ottawa felt it was less damaging to cut transfers to the provinces than to cut in other more politically explosive areas such as Aboriginal programming, old age pensions or unemployment insurance. Constitutionally responsible for the delivery of these services, the provinces were forced to assume a much larger share of the cost of these programmes at a time when most were already saddled with severe deficits and exploding health care expenditures. Thus began efforts on the part of the provinces to find common-ground positions on the need to clarify responsibilities in the field of social policy, reduce programme replication and overlap, and constrain the federal spending power.

The provincial efforts had intensified as the federal government gradually regained control of its finances and used its new 'spending power' to launch one controversial initiative after the other in areas under provincial jurisdiction. For instance, the federal budget of 1997 gave birth to the Canadian Foundation for Innovation, the Canada Millennium Scholarship Fund, the National Child Benefit, and the Health Transition Fund. In other words, "the federal government decided to make itself more visible and

influential through programmes of direct funding to individuals and institutions in areas of provincial jurisdiction, instead of simply restoring funding to pre-1995 levels or vacating room through tax-point transfers to allow provincial government to raise more revenues through tax increases."

From 1995 to mid-1998, the Quebec government did not take active participation in interprovincial talks because others provinces were not yet ready to agree to its basic demand, that was the "recognition of the unconditional right to opt out with full financial compensation for any province wanting to fully assume its responsibilities in areas of exclusive provincial jurisdiction." This had always been a demand of all previous Quebec governments, irrespective of their political obedience, based on strictly following the division of powers enunciated in the 1867 Constitution. In August 1998 in Saskatoon, at a meeting of all provincial and territorial leaders, other provinces finally agreed to this fundamental Quebec demand. Thus, a provincial common front based on what came to be known as the Saskatoon consensus took birth. "It must be noted, though, that the Quebec government was, from the start, under no illusions as to the solidity of this common front." Despite this major Quebec gain, another section of the Saskatoon document made it clear that no element of the SUFA was agreed until everything was agreed to. Just four days before the signing of SUFA by Ottawa and all provinces except Quebec, a key meeting of all provinces on 29 January 1999 in Victoria (British Columbia) reaffirmed the provincial common front born in Saskatoon in August 1998. Titled *Securing Canada's Social Union into the 21st Century*, the Victoria document, which supposedly reflected what was still the common position of all provinces, highlighted among other points:

- a recognition that provinces have primary constitutional responsibility for social programmes;
- a recognition of the importance of clarifying the roles and responsibilities of each order of government and of avoiding overlap and duplication;
- a recognition of the right to opt out with full financial compensation for all new or modified Canada-wide programmes and to submit the launching of any of these programmes to the consent of a majority of provinces;
- a recognition of the importance to ensure stable, predictable and adequate financial arrangements restored at the pre-cuts levels and valid for a five-year period;

- a recognition of the commitment to eliminate unreasonable barriers to interprovincial mobility while also maintaining the ability of governments to pursue legitimate public policy goals; and,
- a recognition of the necessity to establish a dispute-resolution mechanism involving when necessary recourse to a third party.

As it turned out, prior to 4 February 1999, all provincial governments except Quebec made a number of key concessions during unofficial negotiations with the federal government (most notably on the opting-out provision) and finally signed with Ottawa an agreement which was much closer to the federal position than to the provincial one born in Saskatoon and reiterated in Victoria. It was, thus, without the signature of the government of Quebec that SUFA came into existence. For the record, these were the exact positions of Quebec during the 4 February 1999 meeting between Prime Minister Jean Chrétien and his provincial counterparts when SUFA was signed without Quebec, as taken straight from the briefing books of the Quebec delegation:

> Roles and Responsibilities
>
> a) A fundamental principle of the agreement must be the recognition of the primary responsibility of the provinces, under the constitution, for the elaboration of social policy and the delivery of social programmes.
>
> Federal spending power
>
> a) The Saskatoon consensus must be viewed as an important compromise for Quebec.
> b) The opting-out provision with full financial compensation must be applied to direct transfers to individuals and organizations as well as modified social programmes.
> c) The federal commitment on the spending power is limited only to a new Canada-wide initiatives resulting from conditional transfers to the provinces.
> d) The federal proposal makes thus possible a repetition of the Millennium Scholarship scenario.
>
> Funding
>
> a) There is a need for the federal government to formally make a commitment not to reduce the level of its contributions to social programme funding without three years' prior notice. Moreover, it must give priority to re-establishing funding through the CHST to pre-1995 levels and take into account cost increases in the healthcare system.

Mobility
a) Quebec is prepared to commit itself to abolishing unreasonable barriers.
b) Quebec is prepared to implement within one year an internal process to examine potential barriers to mobility and to produce and make public a report on its finding.
c) The comprehensive commitment and examination process must take into account the notions of "reasonableness" and of "legitimate public-policy objectives".
d) Quebec is not prepared to abolish within three years all barriers to mobility as well as
make specific commitments on university quotas and differential tuition fees.

Accountability
a) Each government must report to its taxpayers on the assessment and the results of its social programmes.
b) Quebec is firmly opposed to the development of comparative results indicators through which the federal government wishes to compare the provinces, especially in the health sector, without taking into account specific conditions in the provinces, their health care systems and financing capacity.

Dispute settlement procedure
a) Quebec agrees with the intervention of a third party responsible for making recommendations in a non-binding report to the governments in question. The report should be made public if the dispute persists following the mediator's intervention.
b) While Quebec has always refused to recognize the Canada Health Act, it believes that a joint interpretation of the legislation would be preferable to the current unilateral federal interpretation of it.
All along, the government of Quebec knew that participation in a fragile provincial common front was a risky course of action, but it reasoned that non-participation would not have been a better option (Facal 2005).

Though, it is a non-legally binding administrative agreement only valid for three years and not a constitutional accord, SUFA was seen in Quebec at the time as a major breakthrough for the federal government. Not only did it break the Saskatoon interprovincial consensus and isolate Quebec, but it clearly recognised most of the fundamental principles and goals held by the federal government during the negotiation process. Most crucially, from a historical point of view, it is to our knowledge the first time ever the provinces officially acknowledged and, therefore, gave political legitimacy to the federal government's 'spending power' in the areas of exclusive provincial jurisdiction, without limiting its use in any significant way nor obtaining any other

substantial concession in return. But, it seems a slight overstretch to say that the distance between the Saskatoon interprovincial consensus and SUFA can be measured in light years.

The SUFA once again isolates Quebec, confirming the ability and willingness of the other governments to define and redefine the country without seeking the approval of the Quebec government and without recognising the distinctiveness of Quebec society. In this context, Noël (2000), a political scientist, makes three major points.

(i) He first shows how SUFA turns upside down the provincial point of view regarding the status of the different governments: Rather than recognizing the provinces' primary responsibility for social policy, the SUFA simply evokes the respect of each government's "respective constitutional jurisdictions and powers." It is no longer a question of clarifying roles and avoiding duplication and overlap. Rather, the purpose is to "publicly recognize and explain the respective roles and contributions of governments." Far from recognizing provincial primacy, the Framework Agreement in fact affirms and highlights the federal government's role.

(ii) The second major point Noël makes is: SUFA contains provincial and territorial "explicit and almost unrestricted recognition of the legitimacy of the federal spending power in fields of provincial jurisdiction". Though the federal spending power has no clear and well-defined constitutional foundation, SUFA views it as "essential" for pursuing "Canada-wide objectives" and says it is so "under the constitution". Nowhere does SUFA recognize that social policy is in most instances an area of exclusive provincial responsibility, but instead calls on the governments to act "within their respective constitutional jurisdiction".

(iii) His third major point is that the federal spending power is almost unrestricted in SUFA. Ottawa pledges not to initiate new transfers to provinces without the consent of a majority of provincial governments, but a majority can now mean as little as six provinces accounting for 15 per cent of Canada's population, well below the traditional

constitutional threshold of seven provinces representing 50 per cent of the general population. Even more important, these minimal, self-imposed constraints only apply to new transfers to provinces, which have not been Ottawa's preferred vehicle for years.

According to Michael J. Prince (2005), the SUFA addresses several elements of citizenship and several policy instruments. The most obvious, perhaps, is exhortation. The following are among the values and initiatives to which the accord commits the governments:

- The equality, rights, and dignity of all Canadians;
- Full and active participation of all Canadians in Canada's social and economic life;
- Opportunities for Canadians to have meaningful input respecting social policies and programmes;
- A full review of the agreement and its implementation;
- The mobility right of Canadians to pursue opportunities anywhere in Canada;
- Access for all Canadians, wherever they live or move in Canada, to essential services;
- Social programmes and services of reasonably comparable quality nationwide;
- Appropriate mechanisms by which citizens can appeal unfair administrative practices and lodge complaints about access and service.

Another prominent feature of the agreement is its emphasis on citizen engagement, or participatory citizenship, in policy processes. The agreement includes stated commitments to ensuring that effective mechanisms are in place not only for informing Canadians of decision processes (e.g., accountability and transparency features), but also for involving Canadians in developing social priorities and in reviewing the performance and outcomes of social programmes. The agreement deals with information as a governing tool – that is, the monitoring of programmes, the sharing of results with other governments and the public, joint planning, consultation, and the provision of reciprocal notice on intended policy reforms. To receive their share of funding for new social initiatives, all provincial and territorial governments would need to meet or commit to

meeting the agreed Canada-wide objectives and need to respect an agreed accountability framework. The agreement states: “Each provincial and territorial government will determine the detailed programme design and mix best suited to its own needs and circumstances to meet the agreed objectives. A provincial-territorial government, which because of its existing programming, does not require the total transfer to fulfil the agreed objectives would be able to reinvest any funds not required for those objectives in the same or a related priority area.” The accord is silent on initiatives that are less than Canada-wide, such as bilateral or regional intergovernmental agreements. The SUFA does not include rules or commitments regarding either (1) existing direct transfers to individuals through income-benefit programmes or through the system for taxing personal income or (2) existing direct transfers to organisations for capacity building or research and innovation purposes.

With respect to new transfers to individuals and families or to organisations, the agreement does commit the federal government to give at least three months’ notice and to offer to consult with provinces and territories.

From the above discussion, the SUFA reflects the long-standing position taken by the federal government that it should have the right to initiate transfer programmes to individuals and organisations when only federal funds are involved, without the requirement of formal approval by other governments. Hence, the SUFA has different governance rules for existing and new transfers and no rules for most of the other policy roles played by the federal government in social development. By itself, the agreement appears not to pose great barriers to social initiatives by the federal government acting on its own or in partnership with the provinces and territories. The SUFA is a rather soft set of governance rules for IGR is revealed by the continued implementation, over the last five years, of federal social policy initiatives in the areas of provincial jurisdiction with little or no prior consultation and by the move towards earmarked transfers for early childhood development and healthcare under the CHST. At the same time, however, scope for policy and programme diversity and discretion by provincial and territorial governments is quite evident in the recent federal-provincial-territorial (FPT) agreements

on early learning and child care. As a result, more social policy divergence across jurisdictions in Canada will be seen in all likelihood over the next several years.

As has been noticed, instrument choices for welfare states are multiple and diverse, yielding various blends of social policy, provision and governance. There are seven main policy tools in the provinces' and federal government's repertoire for addressing public needs and implementing social programmes. These tools are voluntary action, information and exhortation, direct public expenditures, tax expenditures, service provision, regulation, and taxation. The same policy tool can be used for a remarkable variety of economic and social purposes.

How governments choose policy instruments is shaped by when and why they undertake public action. Process, context and rationale all must be considered. "Policy analysts have to know which way the wind is blowing," Leslie Pal has remarked, "or instruments that they may recommend for good policy reasons may turn out to have little or no legitimacy among the wider public" (Pal 1997: 103) – and, one can add, little credibility among politicians, bureaucrats, interest groups and journalists. Since Pal wrote this, the fiscal fortunes of the federal government have dramatically improved and there has been a shift from fiscal-deficit politics to fiscal-dividend politics.

The belief that the federal government can and should be an active agent of social change, offering new blueprints of reform, is gaining greater importance again. This potential activism is apparent in the SUFA, which both structures and strengthens the federal 'spending power' for future initiatives. This is probably the most controversial part of the agreement (Clarkson and Lewis 1999; Gagnon and Segal 2000; and McIntosh 2002). A paradox, for some provinces at least, was that in order to regulate the federal 'spending power', they had to recognise its existence. The agreement endorses a positive view of the federal 'spending power', as a governing instrument only loosely conditioned by formal commitments to joint planning and collaboration, advance notice and consultation, and dispute avoidance and resolution. The relative autonomy of the federal state, it seems, is maintained.

According to its preamble, the principles of the SUFA is a reflection of fundamental democratic values and intergovernmental cooperation "based upon a mutual respect between orders of government and a willingness to work more closely together to meet the needs of Canadians."

PRINCIPLES

Canada's social union should reflect and give expression to the fundamental values of Canadians – equality, respect for diversity, fairness, individual dignity and responsibility, and mutual aid and responsibility for one another.

Within their respective constitutional jurisdictions and powers, governments commit to the following principles:

All Canadians are equal
Treat all Canadians with fairness and equity

- Promote equality of opportunity for all Canadians
- Respect the equality, rights and dignity of all Canadian women and men and their diverse needs

Meeting the needs of Canadians

- Ensure access for all Canadians, wherever they live or move in Canada, to essential social programs and services of reasonably comparable quality
- Provide appropriate assistance to those in need
- Respect the principles of medicare: comprehensiveness, universality, portability, public administration and accessibility
- Promote the full and active participation of all Canadians in Canada's social and economic life
- Work in partnership with individuals, families, communities, voluntary organizations, business and labour, and ensure appropriate opportunities for Canadians to have meaningful input into social policies and programs

Sustaining social programs and services

- Ensure adequate, affordable, stable and sustainable funding for social programs

Aboriginal peoples of Canada
For greater certainty, nothing in this Agreement abrogates or derogates from any Aboriginal treaty or other rights of Aboriginal peoples, including self-government.

Source : McLean (2000)

One needs to understand why this agreement came up in 1999. In the 1980s and 90s, there were lots of federal cuts in social transfers to the provinces as the federal government was fighting its own fiscal deficit and debts, besides it had to comply with the provisions of Canada-U.S. Free Trade Agreement (CUFTA) and North American Free Trade Agreement (NAFTA) in removing fiscal support and subsidies. The creation of the CHST in the 1995 and subsequent deletion of the Established Programmes Financing (EPF) and Canada Assistance Plan (CAP) shook federal-provincial relations.

The perception that the federal government was unilaterally changing the face of the social policy landscape upset the provinces as it burdened them with extra financial responsibilities. Former Saskatchewan Premier Roy Romanow suggested that such unilateral actions had endangered the social union because Ottawa had ignored the balance of federalism and the constitutional division of powers. In the 1995 budget, the federal government unilaterally imposed a C$6 billion cutback in transfers to the provinces for healthcare, post-secondary education and social services. The provinces responded to federal cost-containment measures and unilateral cuts in transfers, especially those found in the 1996-97 federal budget, with a restructuring of federalism, which would focus mainly on renewing social policy through more collaborative federal-provincial relations (Statler 2002). The result of these discussions was the SUFA. SUFA was signed in February 1999 by the federal government, nine provinces and two territories. Only the Quebec government refused to sign SUFA. It grew out of a concern to limit the federal 'spending power' in the areas of exclusive provincial jurisdiction, ensure stable and sustainable funding for social programmes like health, post-secondary education, transparency and public accountability, and manage intergovernmental disputes (Facal 2005).

SUFA asked both the federal and provincial governments to work collaboratively so as to attain prescribed and specific policy goals. In the area of healthcare, the federal government under the Liberals (1999-2006) defined itself as the guarantor of equality of access to healthcare and resisted efforts by the Conservative provincial governments to introduce user fees or increase the role of the private sector. The role of the private sector in the area of healthcare re-emerged more in 2004 when a new health agreement had to be worked out between the federal and provincial governments, necessitating the building of a national consensus (Banting 2008: 155).

In this context, the SUFA affects not only federal funding, but also Canada Health Act (CHA). As has been discussed and described earlier, CHA of 1984 sets out healthcare provisions that apply to all Canadians. According to Duckett and Adrian Peetoom (2013): "The Act gives Canadians access to hospitals and physicians for the health services they need without any straight payment."The Act also lays down five criteria that provinces

must meet to be eligible for money transfers i.e. public administration, comprehensiveness, universality, portability and accessibility”. Here one needs to understand that CHA is not merely a health act; importantly, it is also a spending act. It provides money in the national interest, but with ‘conditionalities’.

The dynamics of healthcare system since SUFA 1999 capture the essence of the working of Canadian federalism, importantly its changing contours. SUFA has brought in several meaningful changes in IGR: (i) ‘collaborative’ practices to improve primary healthcare and quality of health services; (ii) use of the federal ‘spending power’ to enforce ‘conditionalities’ on provinces; and (iii) funding earmarked for specific health programmes only. As an intergovernmental agreement, SUFA is described as being a landmark agreement with regard to federal ‘spending power’. One needs to understand that SUFA entails commitments on the part of the federal government to work collaboratively with the provinces in the development of new programmes and not to introduce new programmes without the agreement of a majority of the provinces, and also a commitment to a collaborative mechanism for resolving disputes and further to consult with the provinces and territories one year in advance of any changes in transfer payments (Wilson 2000).

Robert B. Asselin (2001) argues that SUFA affects federal funding for healthcare, interpretation of the CHA and the development of new healthcare initiatives. The SUFA signifies a movement towards a more collaborative style of federalism in the field of healthcare. The main features of this new relationship are the commitment to obtain provincial agreement before introducing new programmes and the agreement on a collaborative mechanism for settling disputes. Also, the federal government now is more closely monitoring provincial health systems. The provinces appear willing to compromise on their original demands for increased autonomy in exchange for additional federal transfer payments. The framework agreement and the Health Accord can be considered an endorsement of a “national” healthcare system, with a reaffirmation of national standards and the principles of the CHA.

Three Reports on Healthcare: Mazankowski Report (2002), Kirby Report (2002) and Romanow Report (2002)

Three major government sponsored commissions have proposed blueprint for future healthcare reform in Canada. These are: the Mazankowski report (2002), the Kirby report (2002) and the Romanow report (2002). In 2002, on the future of healthcare, several key reports were released, each of which outlined visions in order to reform the Canadian healthcare system. At the federal level, there were the Report of the Commission on the Future of Health Care in Canada (the "Romanow Report") and the Report of the Senate Standing Committee on Social Affairs, Science and Technology (the "Kirby Report"). At the provincial level, the Government of Alberta released the 2002 Report of the Premier's Advisory Council on Health (commonly referred to as the "Mazankowski Report").

The Mazankowski Report

In August 2000, Alberta Premier Ralph Klein asked Don Mazankowski for recommendations on how to control increasing healthcare costs. On 8 January 2002, the Mazankowski Report was released and called for increased private funding where insured services would no longer be provided solely by Medicare. Among the forty-four recommendations, the report proposed more limited coverage of Medicare, new sources of revenue, province-wide healthcare standards, and a requirement that physicians work a percentage of the time in the public system. In addition, the report suggested reduced waiting times with guaranteed access to certain procedures within ninety days of diagnosis. In response to the report, the government of Alberta is waiting to see what actions the federal government takes before making significant changes.

The Mazankowski Report identified 10 key themes regarding the report itself and healthcare reform in general:

> Long Term Reform: The Report is not about quick fixes or reducing costs in the short term. Instead, the objective is to reform the system over a longer term. Moreover, the Report is not about broad general ideas or approaches, but attempts to provide practical ideas and solutions to address the sustainability of the Alberta healthcare system.
>
> Equitable Health Care**:** A central position of the Report and its recommendations is that Albertans should have fair and equitable access to health services. No one should be denied access to essential health services because they are unable to pay.

Promoting Health: The Report posits that the best long term strategy for sustaining the health system is to encourage people to stay healthy. If Albertans and policymakers focus simply on treating people when they get sick, the increasing costs of new treatments and technology could bankrupt the system.

Rejecting Rationing: All Albertans should have access to the very best healthcare when they need it. And it should be available to everyone on equitable terms.

More than Efficiency: There is a need to extract maximum value for every dollar spent on healthcare. Such measures alone, however, will not be sufficient to match increasing demands and costs in the healthcare system.
New Ways of Paying: The burden of healthcare on the tax system is growing and will continue to grow with new treatments, new cures, new drugs, and growing demand. As such, there is a need to explore new ways of paying for healthcare.

Rethinking Medicare: It's time to think carefully about what medical services should be covered by public health insurance. The system was never designed to cover all aspects of health services, but people have come to expect that it will – and at no cost to individuals.

Innovation and Competition: There is a need to innovate. It is time to open the system up, allow health authorities to try new ideas, encourage competition and choice, and see what works and what does not.

Patient orientation: There is a need to develop a patient oriented system that encourages empowerment, accountability, and continuous quality improvement.

Made in Alberta Approach: Albertans and policymakers must create their own alternative – one that preserves the best of the current system while also ensuring it can be sustained into the future.

The Kirby Report

The Standing Senate Committee on Social Affairs, Science and Technology[1] studied the Canadian healthcare system for two years. The final report, named the Kirby Report after Senator Michael Kirby, was released on 25 October 2002. A key component of the report was a tax that would raise $5 billion a year to expand hospitals, buy new equipment and

[1] The Standing Senate Committee on Social Affairs, Science and Technology shall be authorised to examine and report upon the state of the healthcare system in Canada. In particular, the Committee shall be authorised to examine:
a) The fundamental principles on which Canada's publicly funded healthcare system is based;
b) The historical development of Canada's healthcare system;
c) Publicly funded healthcare systems in foreign jurisdictions;
d) The pressures on and constraints of Canada's healthcare system; and
e) The role of the federal government in Canada's healthcare system.

recruit doctors and nurses. In addition, the report called for a Care Guarantee to establish maximum waiting times for each medical procedure. Under this system, if patients waited longer than the guaranteed time, provincial governments would be required to provide those services through other means, such as by paying for out of province or out of country treatment. While the report encouraged the preservation of Medicare, Senator Kirby warned that if the recommendations were not adopted, a very convincing case could be made that private health insurance is necessary. He suggested that "a contribution of direct payments by patients, allowing private insurance to cover some services, even in publicly funded hospitals, and an expanded role for the private sector in the delivery of health services are the factors which have enabled countries to achieve broader coverage for all their citizens." The key recommendations of the Kirby Report have not been adopted at the federal level.

The Romanow Report

Roy Romanow was appointed in April 2001 to head the Commission on the Future of Health Care in Canada. The Commission's task was to make recommendations on how to preserve Medicare in Canada. The Romanow Report was released eighteen months later and contained forty-seven recommendations. Among the key proposals were an increase in federal contributions, stable funding where the governments provide at least a minimum amount of money each year, greater governmental accountability to show how the money is being spent, and the implementation of national drug and home care plans. The Commission observed that long waiting times are the main and, in many cases, the only reason some Canadians say they would be willing to pay for treatments outside of the public healthcare system. The report suggested that provincial governments take immediate action to manage wait lists by standardising criteria and providing clear information to patients. But, the report also insisted that Canadian government maintains equality of access to all citizens and preserve the integrity of Medicare by limiting the private sector. In the Commission's view, while a private health insurance option might improve waiting times for the few who could afford it; it would make the situation worse for Medicare patients because necessary resources would be diverted to the private sector.

In September 2004, in response to the growing concerns about healthcare and waiting times surrounding the Romanow Report, Prime Minister Paul Martin convened a First Ministers Conference. In a “10-Year Plan to Strengthen Health Care”, the ministers agreed to develop a National Wait Times Strategy for the areas of cancer care, cardiac treatment, diagnostic tests, joint replacements, and cataract surgeries. The national wait time benchmarks were to be set by 31 December 2005 and all provinces agreed to meet the benchmarks by 31 December 2007. In addition, the ministers agreed on a $41 billion infusion into Medicare over the ten years. But this additional financing did not solve the problems fully. As Dr. Albert Schumacher said, “the increase has just kept us from bleeding to death” (Dean 2007).

Both reports recommended an addition of more federal funds into healthcare, which subsequently turn into two health accords in 2003 and 2004. In the report, the senators recommended that healthcare funds be used to “buy change and reform”, it did not sustain healthcare as it was structured at the time. It is generally recognised that the accords failed to follow this advice. The Quebec government, like several other Canadian provinces, prohibited citizens from obtaining private health insurance for services already covered under Medicare. The delays in treatment in Quebec’s public system were a problem and patients were forced to wait long periods of time to receive certain medical services. But, because of the restrictions on private health insurance, these patients could not bypass the delays by seeking treatment privately. They were required to wait for treatment in the public system because it was their only option (Dean 2007).

The senators also proposed a “healthcare guarantee” with maximum wait times and warned that if governments could not ensure timely access to care, the courts would decide that Canadians could not be denied the right to purchase private health insurance to get the services they need.

The Supreme Court of Canada made such a ruling in the new famous Chaoulli Case[2] in June 2005, and other cases are currently pending.

Another recommendation in the report was the use of activity based funding for hospitals, which has now been adopted by some provinces. Recommendations in favour of a national home care programme and the expansion of Medicare to cover catastrophic drug costs remain unfulfilled.

All of the three major reports take strong positions on the appropriate role of private financing and for-profit delivery of healthcare services.

Mazankowski and Kirby clearly regard: "'Canadians' substantial investment in healthcare as a rich commercial opportunity for the private sector." According to Dean (2007): "Both assert that subjecting the healthcare sector to entrepreneurial values and market discipline is necessary to modernize it. Mazankowski envisages a significantly expanded role for both private financing and for-profit delivery", while Kirby generally "adheres to the principle of public financing (even envisioning expanding the Medicare monopoly to new services) while embracing market-based mechanisms and an expanded private sector role in delivery. Romanow, by contrast, vigorously supports renewing Medicare around the key principles of public financing and not-for-profit delivery." The Romanow report "advocates a significant expansion of the public insurance monopoly to cover new services, strongly rejects a for-profit role in the delivery of core health services, and suggests that the inroads already made by for-profit providers in key areas such as diagnostic services be rolled back".

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[2] The Chaoulli decision: In June 2005, the Supreme Court of Canada's Chaoulli decision struck down sections of two Quebec laws that prohibited Quebec residents from purchasing private insurance for medical and hospital services covered under the province's public health insurance programme (Premont 2005; Supreme Court of Canada 2005). The case was filed by a Quebec doctor, Jacques Chaoulli and his patient George Zeliotis, who claimed that overly long waiting times in the public system threatened a patient's right to life, liberty and security, and argued in favour of allowing individuals to contract insurance for private healthcare services. It is interesting to note that the question of taking out insurance was not intended to apply to 'participating' doctors, that is, doctors under contract with the public healthcare system. In fact, the court's ultimate decision noted that doctors following the applicable Quebec statute must choose between being paid exclusively by the public system or by a private sector employer. It also prohibited participating and non participating doctors from practicing in the same venue.

Health Accords of 2003 and 2004 and Quebec's Objection of Privatisation: The Chaoulli Case

(a)In 1999 under the SUFA, the federal, provincial and territorial governments (except Quebec) pledged a collective approach to developing social policies and programmes, including health. The 2000 First Ministers' Communiqué on Health increases federal cash for health, sets out key reforms in primary healthcare, drugs, information technology, and equipment. The 2003 First Ministers' Accord on Health Care Renewal commits governments to structural change in healthcare to support access, quality, and long-term sustainability. The 2004 10-Year Plan to Strengthen Health Care expands funding, fleshes out some aspects of the 2003 Accord.

At the First Ministers' Meeting in September of 2004, Prime Minister Paul Martin and the provinces signed a 10-year, $41 billion healthcare agreement. "The importance of this deal is in terms of restoring much of the provincial fiscal shortfall arising from the 1995 federal budget, it also embraced and formally recognized Quebec's specificity."

> While Quebec agreed to work in collaboration with Ottawa and the provinces, Quebec's own policies would be determined "in accordance with the objectives, standards, and criteria established by the relevant Quebec authorities," cited from Asymmetric Federalism that Respects Quebec's Jurisdiction, a Canada-Quebec addendum to the healthcare agreement. In effect, this addendum can be viewed as the federal counterpart to the provinces' recognition of Quebec's distinctiveness contained in the above pharmacare proposal. However, this addresses the reigning-in of the spending power only to the extent that the issue relates to Quebec. This is not likely to be viewed as an acceptable approach to the spending power by the other provinces. Indeed, apparently in the final countdown to the September 2004 healthcare deal, Ottawa verbally agreed that Alberta and British Columbia (and by extension, one would presume, all the provinces) could have the same deal as that offered to Quebec. Since the other provinces have not acted on this option, what transpired may best be described as de jure symmetry but de facto asymmetry. However, the reality that Quebec could be finessed by an asymmetric side deal served to open the way for Prime Minister Paul Martin's relentless exercise of the federal spending power during the remainder of his tenure.

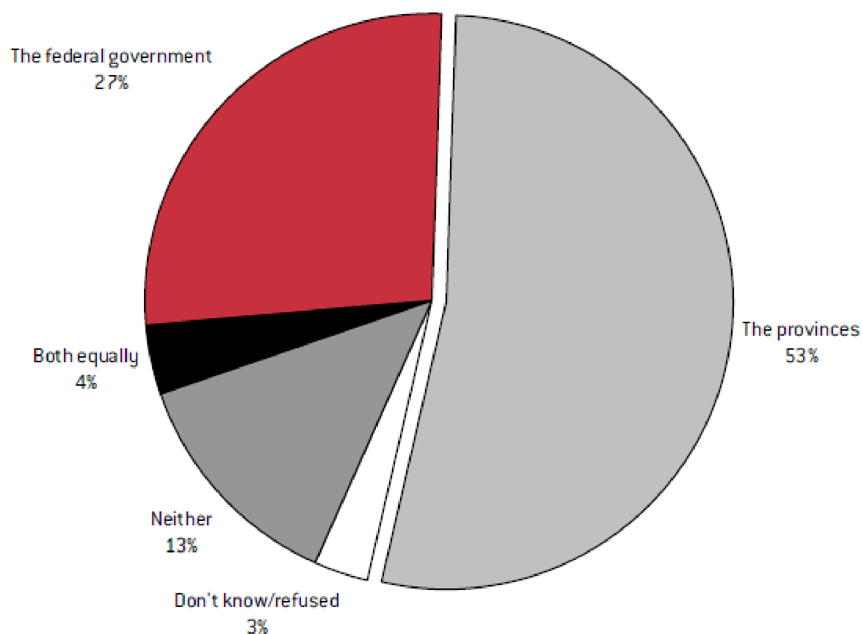
The Health Council of Canada was created as a result of the 2003 First Ministers' Accord on Health Care Renewal to report publicly on the progress of healthcare renewal in Canada, particularly in areas outlined in the 2003 Accord and the 2004 10-Year Plan to Strengthen Health Care. First Ministers have come together and agreed on an action plan based on the following principles:

- Universality, accessibility, portability, comprehensiveness and public administration;
- Access to medically necessary health services based on need, not ability to pay;
- Reforms focused on the needs of patients to ensure that all Canadians have access to the healthcare services they need, when they need them;
- Collaboration between all governments, working together in common purpose to meet the evolving healthcare needs of Canadians;
- Advancement through the sharing of best practices;
- Continued accountability and provision of information to make progress transparent to citizens; and
- Jurisdictional flexibility.

The 2007 Health Council of Canada conducted a public opinion on the healthcare system. Following questions were put before the public to get their preferences regarding healthcare services provided to them:

(1)Which level of government do you have more confidence in to lead changes to the healthcare system?

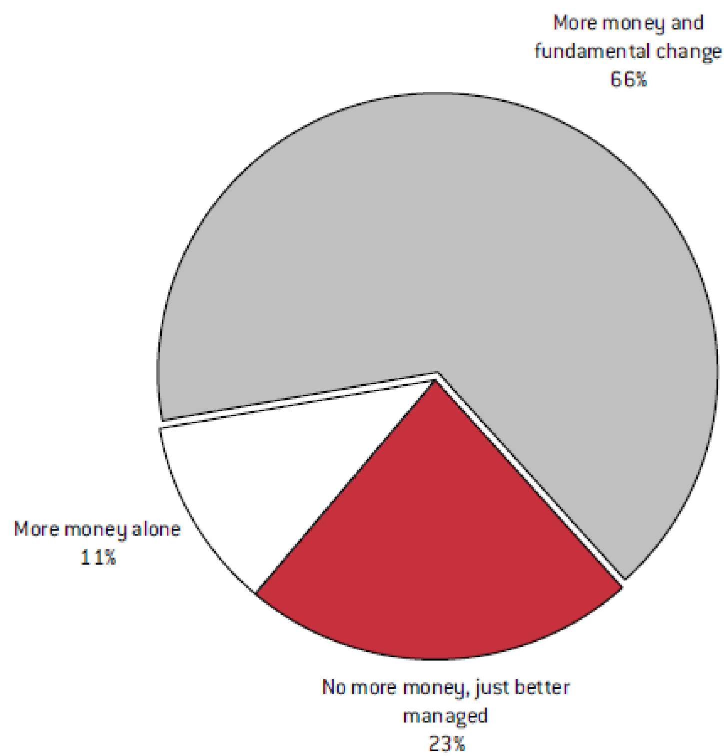
Figure 4.1: Confidence in Federal and Provincial Governments



Source:Soroka(2007)

(2) Some people say that the healthcare system doesn't need more money, it just needs to be better managed. Other people say that more money alone would go a long way to fixing what is wrong with healthcare. Still other people say that more money is required, but that's not enough, the healthcare system needs to be fundamentally changed.

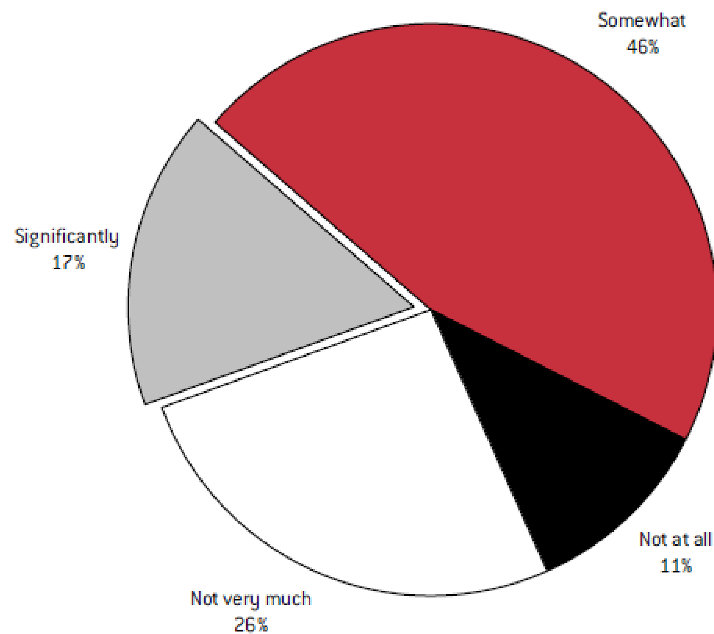
Figure 4.2: Spending, with Fundamental Change



Source: Soroka (2007)

(3) As part of the Health Care Accord, the federal and provincial governments agreed to set up a Health Council with representatives from the public, the healthcare community and governments. Their work will be to ensure that annual reports are prepared to enable Canadians to access how well the healthcare system is doing and how quickly changes are being implemented. Do you think this kind of an advisory group will improve the quality of healthcare significantly, somewhat, not very much, or not at all?

Figure 4.3: Importance of Health Council



Source: Soroka(2007)

From this public view, the quality and sustainability of the healthcare system have come into light as well as the challenges and policy options facing the Canadian healthcare system.

The 2005 Supreme Court decision of Chaoulli v. Quebec Attorney General (A.G.) is the most significant Canadian case vis-à-vis healthcare rights. The two litigants were Dr. Jacques Chaoulli, a physician originally from France who was frustrated with governmental limits on his ability to practice privately, and George Zeliotis, a sixty-seven year old patient with hip and heart conditions who had to wait nine months for a hip operation. One needs to understand that Chaoulli v. Quebec (A.G.) involved a patient who had to wait several months for hip replacement surgery. Together with his physician, Dr. Jacques Chaoulli, the two challenged the Quebec law that prohibited private healthcare insurance for publicly insured health services. They argued that these provisions offended the rights guaranteed by the Canadian Charter of Rights and Freedoms and its Quebec equivalent. Although the case was dismissed by both the trial court and the Quebec appeal court, the Supreme Court agreed to allow an appeal, which it heard on 8 June 2004. On 9 June 2005, by a majority of 4-3, the Supreme Court of Canada ruled that Quebec's ban on private insurance for publicly insured healthcare services violates the Quebec Charter of Human Rights and Freedoms. Three of the same four judges also concluded that the ban violated the Canadian Charter, while three judges held that it did not, with the seventh judge not voicing an opinion on the matter. As a result, while the Court ruled that there was a violation of the Quebec Charter, it did not rule that there was a violation of the Canadian Charter (Dutt 2016).

One needs to understand when the government is unable to offer access to care in a timely manner, there is simply no justification for maintain a strict monopoly on the delivery of required medical care. It is time to adopt the reforms,which are far more accessible to patients(Labrie 2015).

The CHA 1984 specified requirements that "provinces must fulfill to qualify for the full federal contribution, including the provision of all medically necessary services, public administration on a non-profit basis, universal coverage, portability of coverage throughout the country, accessibility of insured services, and a lack of additional patient charges." Further, it specified: "Financial penalties — mandatory dollar for dollar deductions from the federal payment — are imposed on provinces that allow "extra billing and user charges." However, enforcement is limited to these penalties and political

persuasion. Thus, the act does not directly bar private delivery or private insurance for publicly insured services. Although there are laws prohibiting or curtailing private health care in some provinces, they can be changed"(CHA).

One needs to understand that the CHA requires public healthcare insurance plans to be accountable to the provincial government and to be not-for-profit. Moreover, the majority of provinces (Alberta, British Columbia, Manitoba, Ontario, Prince Edward Island and Quebec) prohibit private companies from insuring services that are covered under the public healthcare insurance plans. Four provinces do permit private healthcare insurance for services that are also publicly insured (New Brunswick, Newfoundland, Nova Scotia and Saskatchewan). Thus, patients of 'opted-out' physicians in these provinces can substitute private for public healthcare coverage. Therefore, few people purchase private healthcare insurance (The Health of Canadians – The Federal Role Final Report, Volume Six: Recommendations for Reform, October 2002).

Thus, the notion that Canada's healthcare system is fully publicly funded is illusory; Canada's healthcare system has always been comprised of both public and private regimes. In the pre-Medicare era, subsidised healthcare was limited to those who could afford it to the voluntary purchase of pre-payment plans (supplied initially by voluntary agencies, businesses, local governments, hospital and through such programmes as Blue Cross, which began in 1939). In 1966, it was estimated that of the approximately 20 million Canadians eligible for health coverage, some six million remained uncovered by insurance and another three million enjoyed only partial coverage. In its present state, this distribution must be appreciated from three perspectives: financing – how services are paid for; delivery - how health services are provided to the recipients of care; and allocation - how resources flow from those who finance care to those who deliver it. From a financing perspective, the institution of Medicare signified not only an attempt to provide accessible services and universal coverage for all eligible Canadians, but also served to construct a "triangular relationship" in the healthcare system (Dean 2007).

The imposition of a third-party payment mechanism displaced the bilateral relationship between citizens and private insurers or providers, allowing users free access to a system of services supplied by publicly-paid providers, all of which was supported by publicly-

raised and distributed revenues. The effect of Medicare was to buffer the inequities of the private insurance system through the provision of the public filter that spread financial risks and access across the population. However, the preservation of public insurance is only as good as its parameters allow. Under the CHA, such protection extends generally to the provision of hospital and physician services. Those services not captured by the CHA are open to private provision. This is of particular significance in an era in which new technology is facilitating procedures and cures that can be more readily administered outside the system.

Conclusion

As mentioned above, SUFA had been signed in February 1999 by the federal government, nine provinces and two territories. Only the Quebec government had refused to support SUFA. SUFA is the only non-constitutional agreement attempting to clarify the respective roles of the federal and provincial governments in the areas of healthcare, social services, and post-secondary education. It grew out of a concern to limit the federal 'spending power' in the areas of exclusive provincial jurisdiction, ensure adequate, stable and sustainable funding for social programmes, transparency and public accountability, and manage intergovernmental disputes.

In 1995, CHST had come as the funding mechanism of the social sector. Under this legislation, the federal government provided the provinces with an unspecified block transfer to cover federal obligations to provincially administered healthcare, post-secondary education, and social assistance. "While this new arrangement has given even greater autonomy to provinces with regard to their expenditures, it has also been a source of conflict between the federal government and the provinces over budget shortfalls, spending cuts and healthcare deficiencies." SUFA has set five specific goals for itself:

(i) working in partnership for Canadians i.e. ensuring greater intergovernmental cooperation in order to serve Canadians better and the federal 'spending power'; (ii) involving Canadians by ensuring greater openness in government and by participation of Canadians as a necessary element in the policy making process; (iii) mobility ensures that Canadians can move anywhere in Canada, while assuring equal access to social

programmes; (iv) dispute avoidance and resolution; and (v) informing Canadians of public accountability and transparency.

The SUFA is a milestone in the healthcare policy making of Canada mainly because the bifurcation of healthcare transfer was achieved only after the recommendation of Romanow Report which followed SUFA agreement. In preparation for the 2004 Health Accord, two major reviews of the health system were conducted: the Royal Commission Report, commonly known as the Romanow Report of 2002; and the Kirby Report, which was a Senate report, released in October 2002. Chaired by Liberal Senator Michael Kirby, it endorsed the concept of private provision of healthcare. The report also proposed expanding public responsibility and funding in the new areas of healthcare such as home care and pharmaceuticals. The Romanow report was more expansionary and an endorsement of the principles enshrined in the CHA and the strong attachment Canadians have to their Medicare. Some of Romanow Report's recommendations were adopted when the Health Council of Canada and Canada Health Transfer were established. Quebec remains unexceptional to the collaborative nature of the healthcare policy in Canada mainly because of its non-participation in SUFA and, later on, its objection to privatisation of healthcare facilities as highlighted by Chaoulli judgement. The autonomy of Quebec province has resulted in the exclusion of their policy structures from a majority of agreements and healthcare policies as applicable on other provinces. The comparison of the provinces is difficult, mainly because of non-uniformity in the transfer of healthcare funds and the implementation of concerned policies.

Thus, the focus of this Chapter was policies and their implementation in the provinces and territories of Canada. The next Chapter deals with an equally important aspect of CHA, which is the financial disbursement and fiscal provision for healthcare services.

CHAPTER V

FEDERAL 'SPENDING POWER' AND CANADA HEALTH TRANSFER

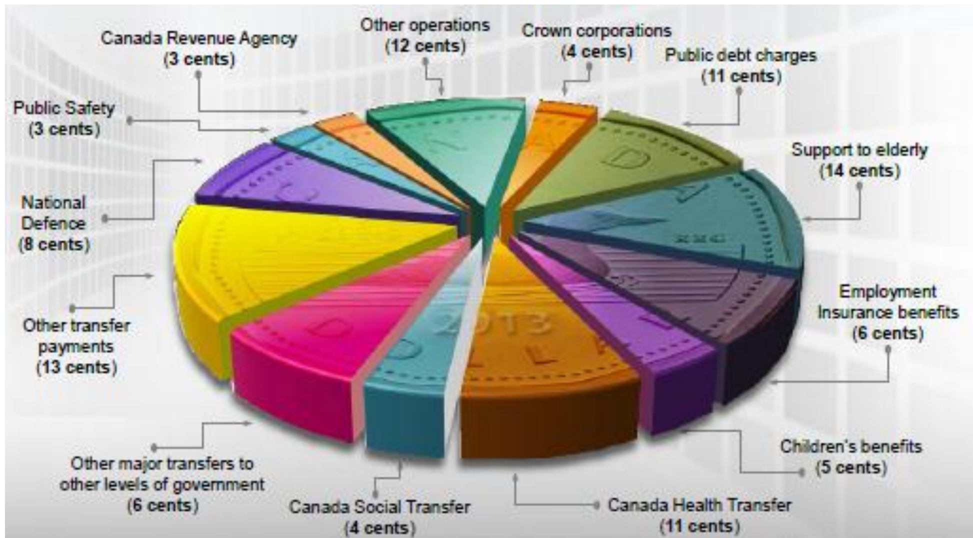
The discussion about the Social Union Framework Agreement (SUFA) and its subsequent agreement misses out on how financial aspect of healthcare provision was handled in different provinces and territories of Canada. The financial provision cannot be studied in isolation with policy decision.

As noted, the 'spending power' involves "the transfer of money or tax points rather than jurisdiction, and areas most affected by it (health, education, welfare and employment training) are already within the provincial jurisdiction." The present Chapter explains the federal 'spending power' in the first section in detail. The second part of the Chapter focuses on the evolution of federal healthcare transfers. It describes diverse methods and mechanism of the federal spending such as cost-sharing, block-grants, specific-targets and time-bound grants. The subsequent section also highlights the introduction of Canada Health Transfer (CHT). The last section of the Chapter focuses on the major findings of the federal support to provinces and territories in CHT and Canada Social Transfer (CST), analysed from the year 2005 to 2015.

The federal government's most important health related power is the 'Power to Spend'. The federal 'spending power' "permits the federal government to make payments to provincial governments in respect of matters over which the provincial and territorial governments have exclusive legislative authority" (McLean 2000). This is how the federal government spends money in the area of healthcare, which otherwise falls under the purview of the state. The constitutional right of a government to 'spend money' also represents "a key lever for the federal government as a means of exercising authority over the provinces and influencing their healthcare policies." Each year, "the federal government gives the provinces billions of dollars to support the delivery of provincial health services and programmes. The federal government regularly places conditions on the provinces in conjunction with these funding" (Makarenko 2008).

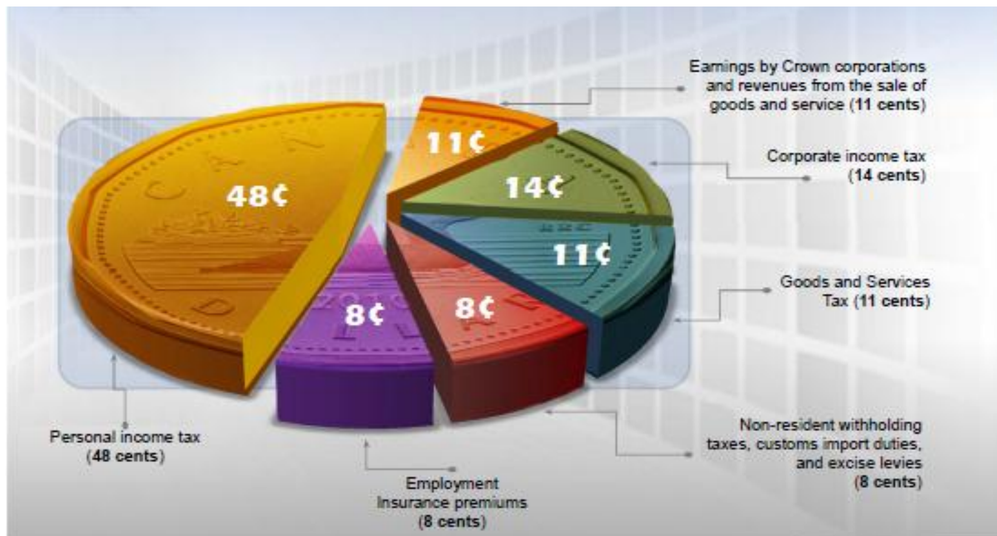
The federal spending in the social sector is shown in the figure 5.1. The CHT provided C$30.5 billion for health programmes and the CST provided C$12.2 billion for post-secondary education, social programmes and programmes for children, which is shown in the figure: 5.1 Federal Spending 2013-14. This raises the question regarding the source of government funding which is answered in the figure 5.2 Sources of Revenue.

Figure 5.1: Federal Spending 2013-14



Source: Department of Finance Canada, 2013-14

Figure 5.2 : Sources of Revenue



Source: Department of Finance Canada, 2013-14

In 2013-14, the federal government received C$271.7 billion in revenues. The above Pie chart shows that the revenue is generated primarily from personal income tax, corporate income tax, goods and services tax, and other taxes like non-resident withholding taxes, customs import duties, excise levies and also employment insurance premiums contributed to federal revenues.

Federal 'Spending Power'

E. A. Dreidger (1981) has suggested that "the 'spending power' first emerged in a constitutional context with the publication of the federal paper in the June 1969, federal-provincial constitutional conference." The 'spending power' is simply "the expansion of the taxing power to the point that the federal government has sufficient revenues to underwrite national programmes, in addition to fulfilling its more specific constitutional mandate."

The 'spending power' involves "the transfer of money or tax points rather than jurisdiction, and areas most affected by it (health, education, welfare, employment training, and regional development) are already within the provincial jurisdiction." Theoretically, at least, "the elimination of the 'spending power' could involve simply the elimination of such federal transfers to the provinces. In practice, the provinces would almost certainly, in return, insist upon a transfer of tax points or actual funds." Thus,

> the concept of federal 'spending power' arises from federal government initiatives immediately following the Second World War and is closely linked with efforts to centralize the taxing power. The funds for a variety of health, education and social development programmes, either unilaterally or in collaboration with the provinces, the federal government substantially altered Canada's approach to issues that were essentially within provincial jurisdiction (Dunsmuir 1991). The 'spending power' thus became the main lever of federal influence in the fields which legislatively fall within provincial jurisdiction, such as healthcare, education, welfare and regional development. Through providing financial assistance to specified provincial programmes, the federal government could influence provincial policies and programme standards.

In June 1969, the federal government presented to a federal-provincial First Ministers' Conference the paper on federal-provincial grants and the 'spending power' of

parliament, which for the first time dealt with the evolving nature of the 'spending power':

> Ordinarily, one thinks of the 'spending power' of governments simply in terms of the expenditure incurred on particular programmes, under the authority of legislation passed by their legislative bodies. Constitutionally, however, the term 'spending power' has evolved a specialized meaning in Canada: it means the power of Parliament to make payments to people or institutions or governments for purposes on which it [Parliament] does not necessarily have the power to legislate (Bayefsky 1989).

The federal 'spending power' in Canada has been defined as "the power of Parliament to make payments to people or institutions or governments for purposes on which it [Parliament] does not necessarily have the power to legislate." According to Dunsmuir (1991), 'spending power' has advantages as well as disadvantages:

Advantages of 'spending power'

- "It can assure a minimum acceptable level of public services in different regions;
- Only national government standards and financing can compensate for mobility effects between regions and
- It enhances the mobility that an integrated common market requires."

Disadvantages of 'spending power'

- "Intergovernmental transfers blur the lines of electoral responsibility
- Conditional transfers interfere with the decision-making powers of the recipient government
- Conditional transfers allow the donor government to make policy in areas where it is not constitutionally competent."

Thus, 'spending power' involves the transfer of cash or tax points rather than jurisdiction, and the areas most affected by it such as health and education are already within provincial jurisdiction. The elimination of the 'spending power' could involve simply the elimination of such federal transfers to the provinces.

Evolution of Federal Healthcare Transfers and Canada Health Transfer

(i) Pre-Blocking Funding Era to 1977/78: the 50:50 Sharing Principle

In 1947, the government of Saskatchewan became the first province to introduce a programme of provincial health insurance. Earlier hospital and medical care in Canada was largely privately funded and individual patients paid doctors for their services and many hospitals run by religious or voluntary organisations. In 1948, the federal government offered health grants to the provinces to help pay for hospital services. This was followed by the Hospital Insurance and Diagnostic Services Act in 1957, through which the federal government offered to share the cost of hospital services.

The sharing of healthcare costs on a 50:50 basis was accepted by the most provinces. In 1966, the Canada Assistance Plan (CAP) was introduced, creating a cost-sharing arrangement for social assistance programmes.

(ii) Transition to Block Funding - 1972/73 to 1976/77

The federal government was concerned as early as 1972 about its exposures to cost escalation in programmes administered by the provinces/territories. The restraint majors adopted by the federal government resulted in considerable fiscal pressure being applied to the provinces/territories:

- The federal government refuses to share hospital and medical care expenses, and other growing healthcare programme areas, such as psychiatric services, home care, drug benefits, etc.
- Therefore, the pressure for change was being applied by some provinces over the potential of cost sharing's "50 cents dollars" as it could distort provincial priorities.

(iii) The Established Programmes Financing (EPF) Era - 1977/1978 to 1995/1996

- The new block fund instituted in 1977/78, the Established Programmes Financing (EPF) arrangements, had distinctive characteristics: the federal "contribution" compromised both a cash payment and a notional "tax point value". The cash payment constituted an actual payment or transfer to provinces/territories and the

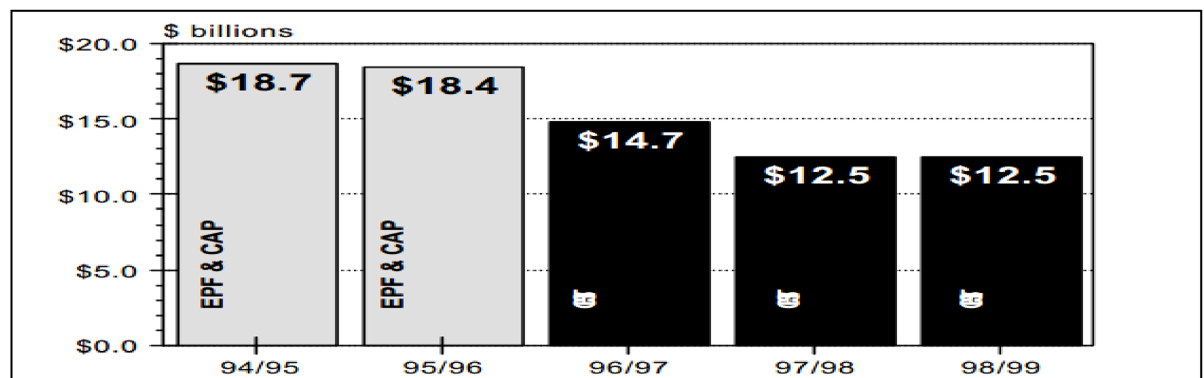
tax transfer reflected the notional value – for a year – of the one time transfer of federal tax room to the provinces.

- One needs to understand that EPF was no longer designed to pay one-half of the cost of provincial health programmes, but rather was to provide equal per capita grants to the provinces to grow at the same rate as Canadian GDP. In 1990, the per capita grant was frozen and restraint continued and finally in 1996, the federal government announced the termination of EPF grants and the creation of a new block grant to support health, education, and post-secondary education: the Canadian Health and Social Transfer (CHST).

(iv) Canada Health and Social Transfer (CHST) - 1996 to 2003

- With the introduction of CHST in 1996/97, the federal government unilaterally initiated a major change in the funding to provinces/territories in support of health, post-secondary education and social services. The federal budget announced that the CAP and EPF combined into one block fund – CHST. At the same time, the federal government imposed significant cuts in the level of transfers to the provinces/territories. As figure 5.3 shows by 1997/98, the value of the federal transfers had fallen to $12.5 billion. The CHST was $6.2billion less than EPF and CAP had been in 1994/95. Like the EPF, the CHST was a combination of the 1977 tax transfer and cash transfer and the total was allocated on an equal per capita basis.

Figure 5.3: The C$6.2 billion Absolute Drop in Funding Levels



Source: Finance Canada cited in Provincial and Territorial Ministers of Health, Understanding Canada's Health Care Costs, 2000.

The 1995 federal budget announced that "beginning in the fiscal year 1996–1997 the CAP and EPF would be rolled into one block fund, thus completing the federal government's gradual move from cost sharing to block funding for major federal transfers." The CHST was a single block fund to the provincial and territorial governments in support of healthcare, post-secondary education, social assistance and social services. With the introduction of the CHST, Budget 1995 noted that:

- Provinces and territories would no longer be subject to rules stipulating which expenditures were eligible for cost sharing.
- Provinces and territories would be free to pursue their own innovative approaches to social security reform.
- Federal expenditures would no longer be driven by the provincial and territorial decisions on how, and to whom, social assistance and social services would be provided.

(v) 2000 and 2003 Health Accords and Canada Health Transfer (CHT)

In 2000, the federal government announced $23.4 billion in new spending over five years on healthcare renewal and early childhood development. At the meeting of the First Ministers or premiers of the provinces in February 2003, there was an agreement on an action plan for renewing healthcare. This would result in an increase in federal support for healthcare and also agreed to restructure the CHST in April 2003 by dividing it into two separate transfers: Canada Health Transfers (CHT) and Canada Social Transfers (CST). So, in 2004, the federal government separated the CHST. The CHT retained the conditions of the Canada Health Act (CHA). The CHT provides block funding to provinces and includes both tax point and cash transfers. The value of the tax point component grows in line with economic activity, while the total CHT cash component is legislated under the Federal-Provincial Fiscal Arrangements Act.

(vi) 2004 10-Year Plan to Strengthen Health Care

In 2004, the federal and provincial governments signed the 10-Year Plan to Strengthen Health Care. To sustain this plan, the federal government committed additional funding to provinces and territories for health that included increases to the CHT through a base adjustment and an annual six per cent escalator. Under the 2004 10-Year Plan to Strengthen Health Care, the Health Reform Transform (HRT) was incorporated into the CHT effective from 1 April 2005. A new HRT targeted to primary healthcare, home care, and catastrophic drug coverage.

In due course of time, "as these programmes became more established, there was a less necessity for the rigorous and comprehensive reporting and auditing required by the federal government." (i) Thereafter, "federal support for national priorities began to shift to 'block funding' based on acceptance of broad principles and shared objectives." The 'block' funding structure gives "provinces and territories greater flexibility in designing and administering programmes. As a result of this evolution, (ii) today government's focus is on accountability to the public, rather than to other levels of governments. (iii) Public accountability frameworks recognise that governments are accountable directly to their residents since they are the ones who pay taxes and receive services."

In 1977, the Established Programmes Financing (EPF) was introduced, replacing cost sharing programmes for health and post-secondary education. With the CHA of 1984, EPF funding was made conditional in respect of the five criteria of the CHA (universality, accessibility, portability, comprehensiveness, and public administration). In 1995, the federal budget announced that the CAP and EPF would be combined into one block fund – the Canada Health and Social Transfer or CHST. "The CHST provided funds to provincial and territorial governments in support of healthcare, post-secondary education, social assistance and social services" (Provincial and Territorial Ministers of Health 2000).

In 2000 and 2003, "the Government of Canada and provincial and territorial governments all entered into a series of agreements, to strengthen and renew Canada's publicly funded healthcare system" (Department of Finance Canada 2011). First Ministers also agreed to

restructure the CHST effective from 1 April 2004 to create two new transfers – the CHT and the CST to improve the transparency and accountability of federal support to provinces and territories. In September 2004, "First Ministers signed the 10-Year Plan to Strengthen Health Care. In support of this 10-year plan, the Government of Canada committed additional funding to provinces and territories for health that included increases to the CHT through a base adjustment and an annual 6 per cent escalator."

The federal government committed to "spending an additional C$41 billion over a decade, and in return, the provinces gave vague assurances that they would reduce wait times for surgery, improve primary care, develop a national pharmaceuticals strategy and invest more in health promotion and prevention". In December 2011, the Harper Government announced a major cut to the CHT of C$36 billion.

The Budget 2007 and 2009 commitments affected the CHT and changes in CHT formula in 2014. After the expiry of legislated funding through the 10-Year Plan to Strengthen Health Care as of 1 April 2014, as committed in Budget 2007 (established a new equalisation formula, originally based on a five province standard of fiscal capacity, but now it began to be determined based on a 10-province standard), the CHT cash transfer will be allocated to provinces on an equal per capita basis. This commitment will benefit provinces that receive less CHT cash per capita than other provinces (Gauthier 2011).

The federal government of Canada provides significant financial support to provincial and territorial governments to assist them in the provision of programmes and services. There are four main transfer programmes: (1) the Canada Health Transfer (CHT), (2) the Canada Social Transfer (CST)[1], (3) Equalisation[2], and (4) Territorial Formula Financing (TFF)[3]. The Chapter attempts to analyse on two aspects, i.e. Total Federal Support, and the Canada Health and Social Transfers (CHST) of ten provinces and three territories. It took data of one decade from 2005 to 2015. The first section focuses mainly on intergovernmental transfers from the federal government to the provinces and territories.

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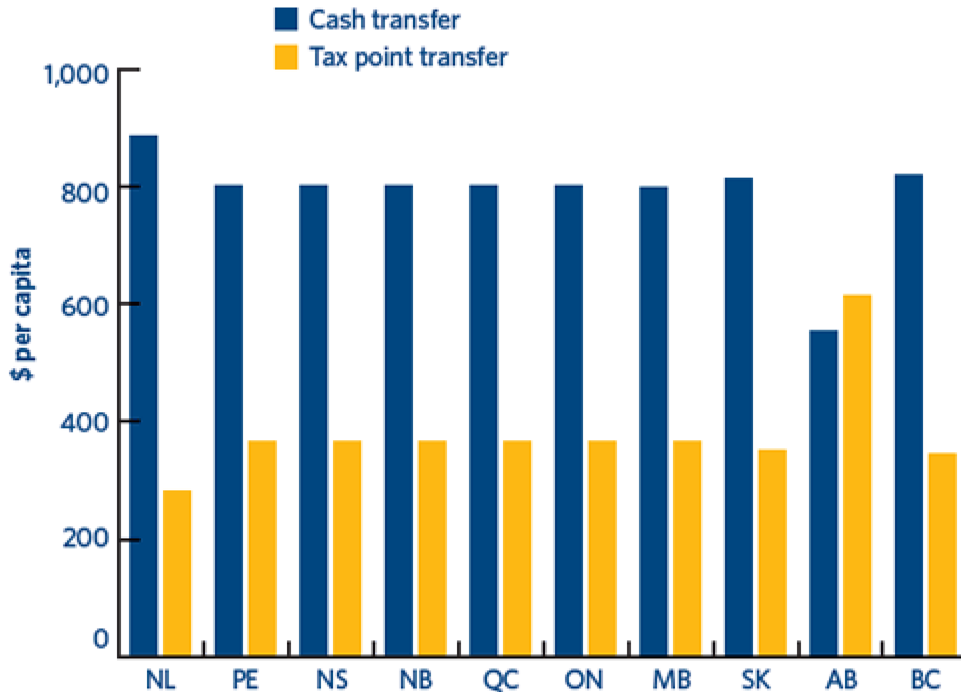
[1] The CST is the primary federal contribution in Canada to provincial and territorial social programmes related to post-secondary education, social assistance and social services, and programmes for children.
[2] Equalisation transfers are made unconditionally to the low-income provinces based on their tax capacities.
[3] TTF is for territories meant to compensate them for the higher per capita cost of providing services which arises due to the small size of their population, large area and weather conditions.

In this section, the tables and graphs have shown Total Federal Support (CHT, CST, Equalisation, TFF and other Payments), and CHT and CST. Both the CHT and CST are conditional grants. For CHT, the five principles of the CHA are attached to use of funds (discussed in Chapter III). The CHT includes a cash transfer and a tax point transfer as mentioned in the Figure 5.4. The total cash transfer is set in legislation and grows by 6 per cent annually. The tax point transfer corresponds to 13.5 percentage points of personal income tax and 1 percentage point of corporate income tax.

Intergovernmental transfers are an important source of revenue for both the provincial and territorial governments, and an important expenditure item for the federal government (Harvey 2014). Transfers are the largest group of government spending. Payments that go directly to persons, to provincial and territorial governments and to organisations are called 'transfers'.

Figure 5.4: Cash Transfer and a Tax Point Transfer



Source: Department of Finance Canada,2011- 2012

In Budget 2007, the federal government committed to remove the equalising component of the CHT by legislating that the cash transfer move to an equal per capita allocation in 2014–2015. The first year of a new agreement following the expiry of the 10-Year Plan:

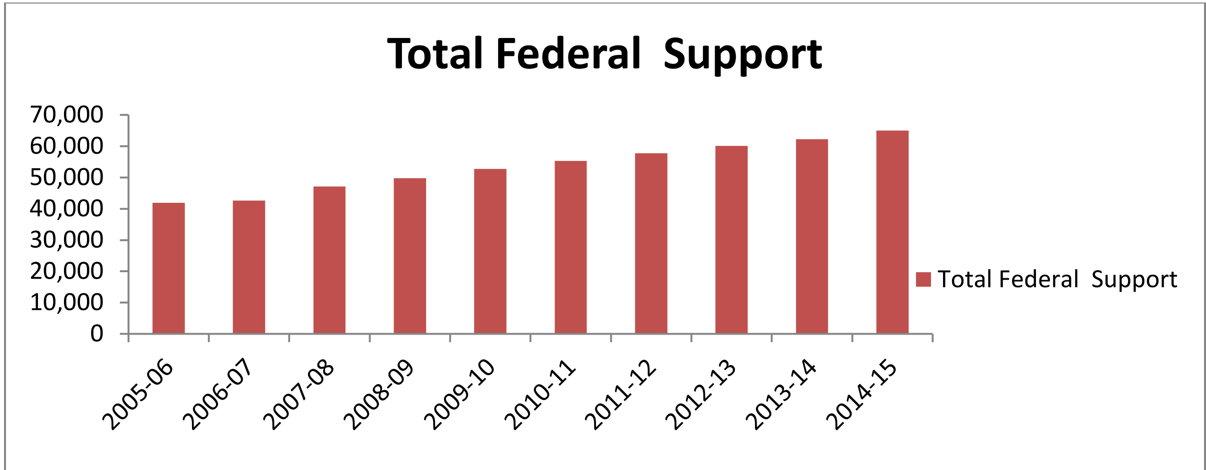
> Concerns about the equalizing component of the cash transfer have been raised more recently due to economic shifts resulting from high natural resource prices, a stronger Canadian dollar, and a decline in manufacturing. For example, even though Ontario became a poorer province relative to provinces with abundant natural resources, its per capita CHT cash transfer continued to be lower than average due to its relatively strong tax point transfer. In response to these recent economic shifts, Budget 2009 facilitated the move to an equal-per-capita cash transfer for Ontario by ensuring that the province immediately receives the same per capita CHT cash as other relatively poorer provinces, and further committed the federal government to work with all provinces on how to transition to full equal-per-capita cash in 2014-2015.

Once, "the overall value of the tax transfer is calculated, it is added to the legislated total cash transfer to obtain the total CHT. The total CHT is then divided by total population to determine per capita total CHT. Each province's per capita CHT cash is calculated as a residual (i.e., the province's per capita share of total CHT lesser its per capita tax point transfer). CHT cash includes an equalizing component since the per capita cash transfer is higher for provinces with relatively weak tax point transfers."

The Federal Spending from 2005 to 2015

In 2014-15, provinces and territories received C$65 billion in major transfers – an increment of C$23.1 billion since 2005-06. These transfers are estimated to account for 19 per cent of provincial and territorial revenues in the financial year 2014-15.

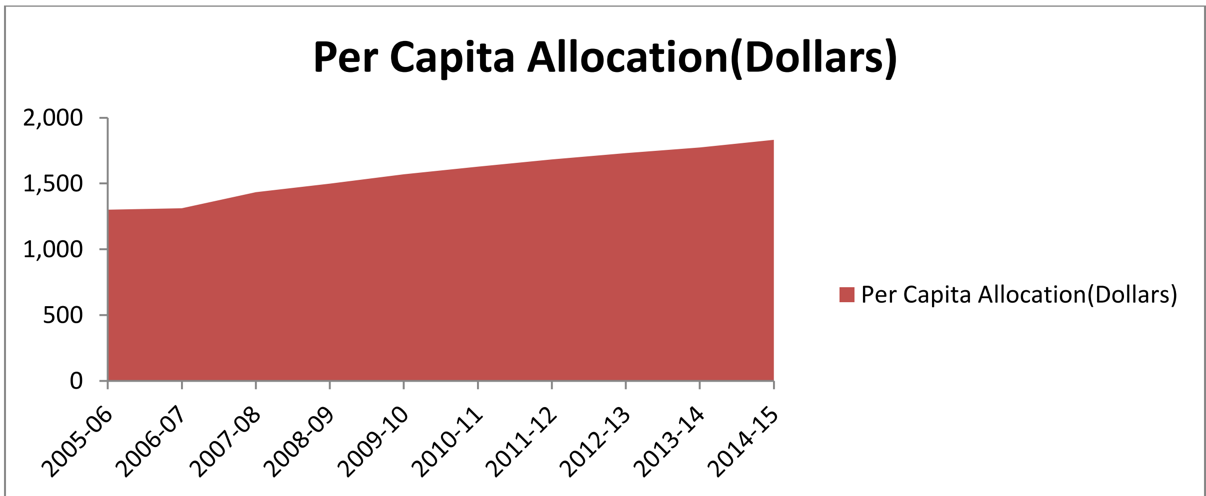
Figure 5.5: Total Federal Support (C$ billion)



Source: Department of Finance Canada, 2005-2015

The diagram depicts an improvement in Total federal support to provinces and territories by the Canadian Government in the decade, which is marked by improved focus of the government on social sector. The comparison between the financial year 2005 and 2015 shows an increment of 23,121(millions of dollars) which is an increase of almost 50.1%.

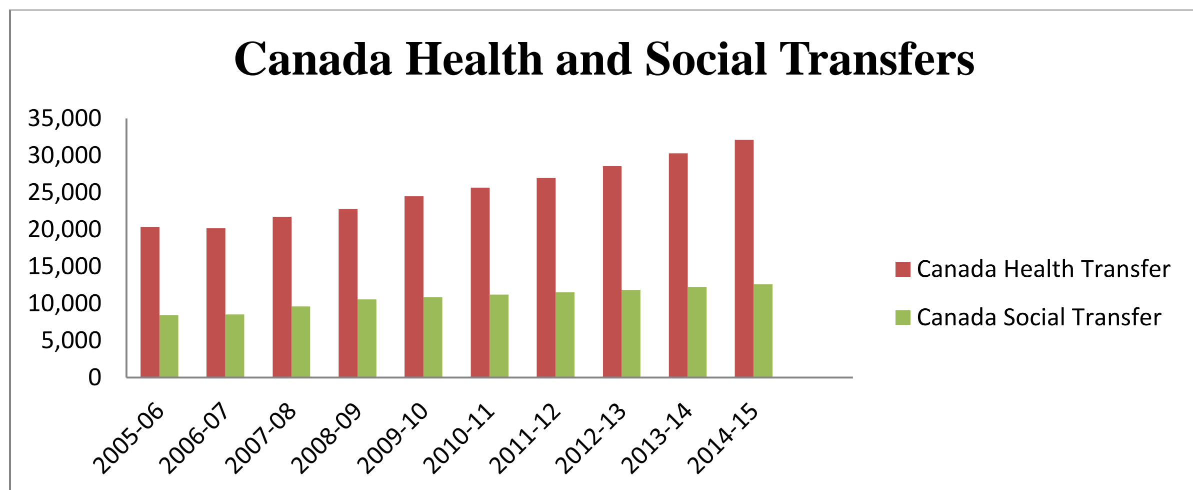
Figure 5.6: Per Capita Allocation (Dollars)



Source: Department of Finance Canada, 2005-2015

The same trend is observed in per capita allocation in social sector spending over the period of a decade starting from 2005-06. Per capita allocation (dollars) is a better indicator of the effectiveness of intergovernmental transfers as it takes into account the population of which the resources are distributed. Same amount of resources with higher population would bring lesser improvement in the quality of services as per person allocation of resources would be low. The above table indicates that per capita allocation for 2005-2006 is C$1,301, and for the financial year 2014-2015 is C$1,832. The comparison between the financial year 2005 and 2015 shows an increment of 531, which is an increase of almost 40.8%.

Figure 5.7: The Canada Health and Social Transfers (C$billion)



Source: Department of Finance Canada, 2005-2015

The above bar chart of Canada Health Transfer (CHT) indicates that in 2005-2006, it is C$20,310, and for 2014-2015 is C$32,114. The comparison between the financial year 2005 and 2015 shows that there is an increment of 11,804 which is an increase of 58.1%. The bar chart of Canada Social Transfer shows that in 2005-2006, it is C$8,415 which increased to C$12,582 in the year 2014-15. The comparison between the financial year 2005 and 2015 shows that there is an increment of 4,176 which is an increase of 38.1%. There is a vast difference in incremental increase of CHT and CST in a decade-wise comparison of two variables. The CHT experienced a much steeper rise in the given period where growth on CST is flatter compared to the earlier variable. It can be

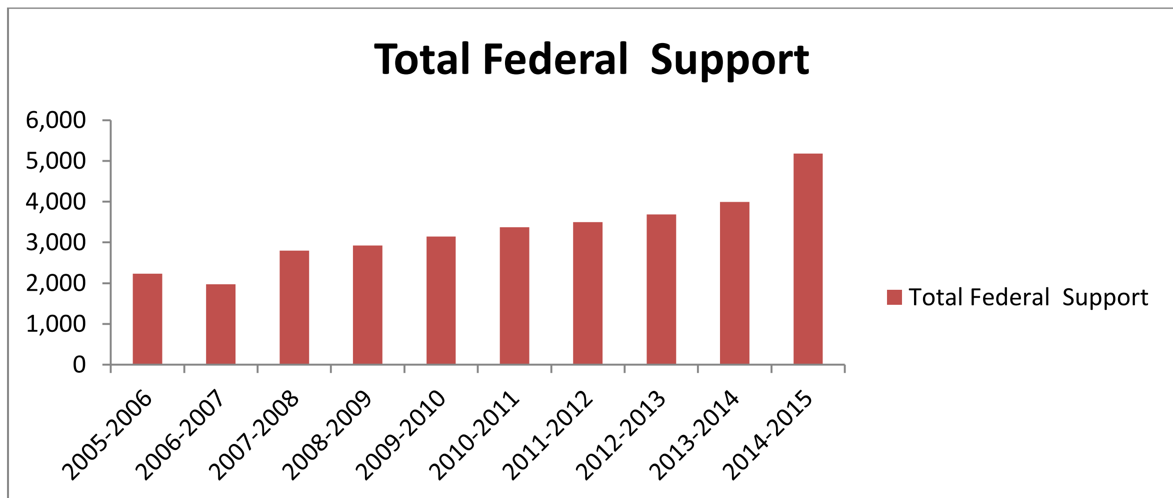
concluded that bifurcation of health and social transfers is a welcome move for the Canada health system.

The Canadian economic development has relied on resource exports of fur, fish, timber, wheat, minerals and energy rather than manufacturing. The Canadian political economy generally termed as the staple economy. The significance of the staple economy has often been greater at the provincial level for such resource industries fall largely within the provincial jurisdiction. Over the next section, ten provinces and territories are analysed on the basis of geographical location and economic situations prevailing in them. The section depicts the changes in the level of health transfers over the last decade (2005-2015).

ALBERTA

Alberta is a province in the western part of Canada. The capital of the province is Edmonton. Its population has consistently grown due to unique and interesting demographic position of the province. Its distinctive political culture and unsurpassed prosperity from resource revenues make it a province *pas comme les autres*(not like the others) in the Canadian federation. Alberta is a "have" province economically since Alberta was historically an agriculture-based economy producing wheat, other grains and livestock. Alberta emerged as an economic powerhouse due to the development of the oil sands and rising oil prices (Inwood 2011).

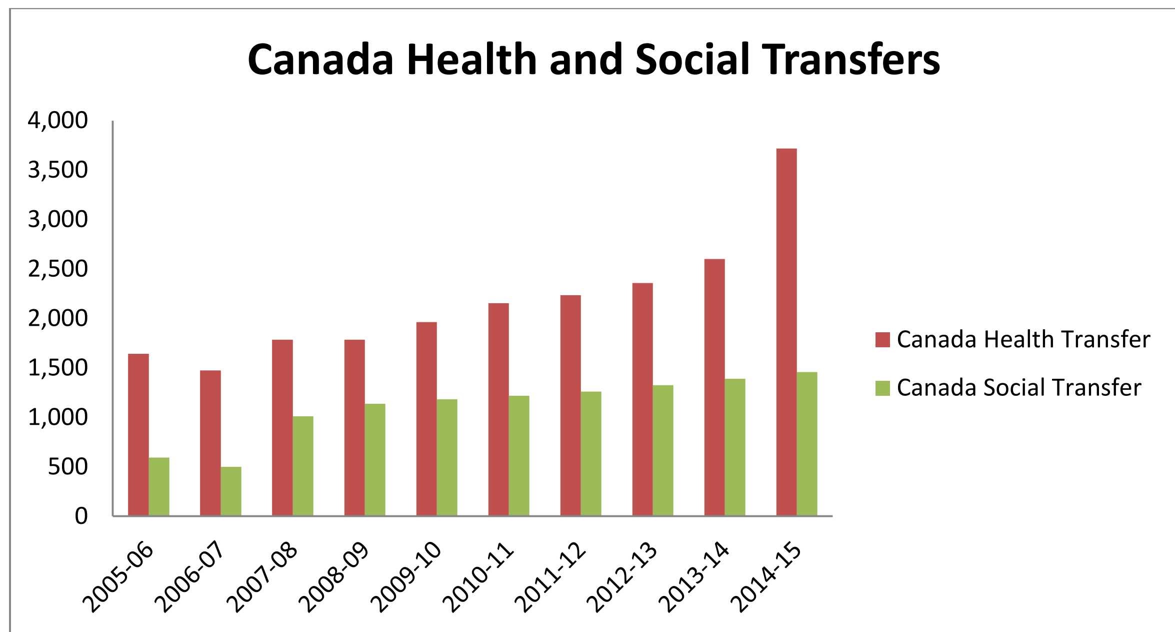
Figure 5.8: Total Federal Support to Alberta (C$ million)



Source: Department of Finance Canada, 2005-2015

The bar chart of Total Federal Support to Alberta indicates that in 2005-2006, it was C$2,233 which reached to C$5,176 in the year 2015, but it was not a unidirectional movement as indicated by the data. There were fluctuations since total federal support from year to year depended on yearly budgetary policies of the federal government.

Figure 5.9: Canada Health and Social Transfers of Alberta (C$ million)



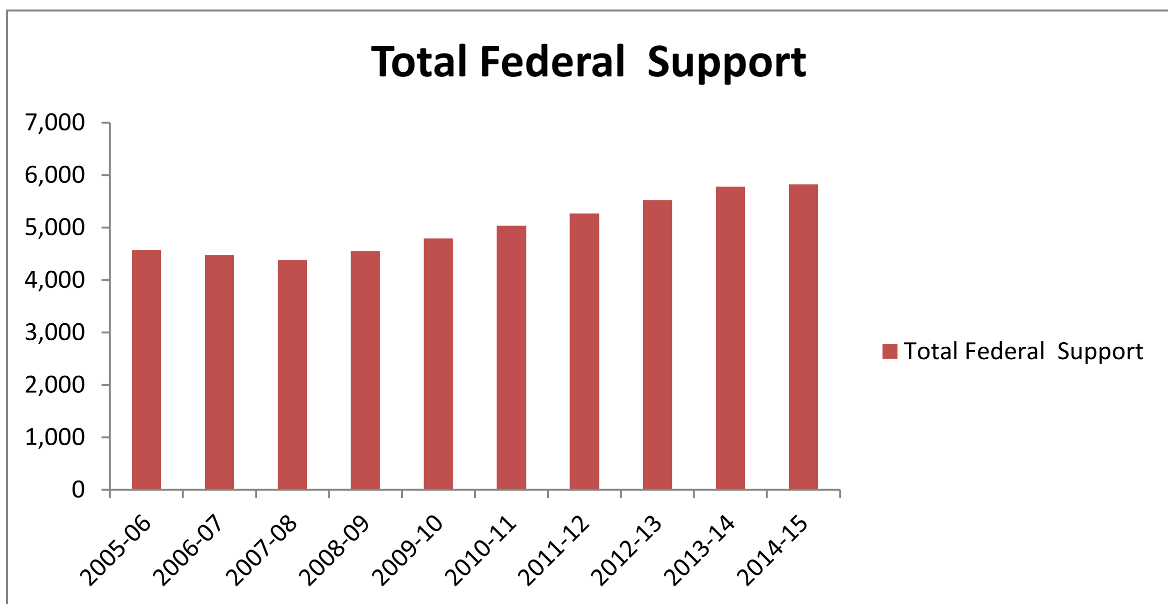
Source: Department of Finance Canada, 2005-2015

The pictorial depiction of Canada Health Transfer indicates that in 2005-2006, it was C$1,641 and improved to C$3,718 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 2,077, which is an increase of 126.5%. The comparison between the financial year 2005 and 2015 in Canada Social Transfer shows the increment of 865, which is an increase of 146.1%. The figure of the Canada Health and Social transfers in Alberta also shows vast fluctuations and dispersions in the above mentioned period.

BRITISH COLUMBIA

British Columbia, situated on the Pacific coast, is Canada's westernmost province. It has a smaller population than Ontario and Quebec and, therefore, relatively less political influence nationally; it is a resource-based economy. This province is a leader in the forestry sector because of the great expanses of forests, while also specialising in the mining of natural gas, copper and coal (Inwood 2011).

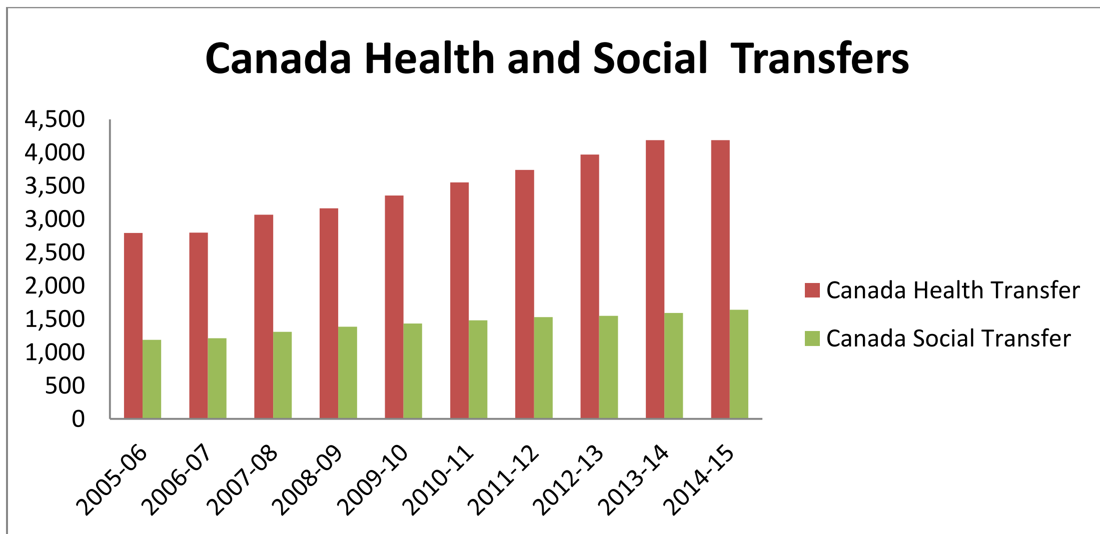
Figure 5.10: Total Federal Support to British Columbia (C$ million)



Source: Department of Finance Canada, 2005- 2015

The bar chart of Total Federal Support to British Columbia indicates that in 2005-2006, it was C$4,573 which started falling continuously for two consecutive years after that till 2007-08. The total federal support saw a constant increase in its amount starting from 2008-09 which continued till 2014-15 and reached the level of C$5,824. The comparison between the financial year 2005 and 2015 shows the increment of 1,251, which accounts for an increase of 27.3%.

Figure 5.11: Canada Health and Social Transfers of British Columbia (C$ million)



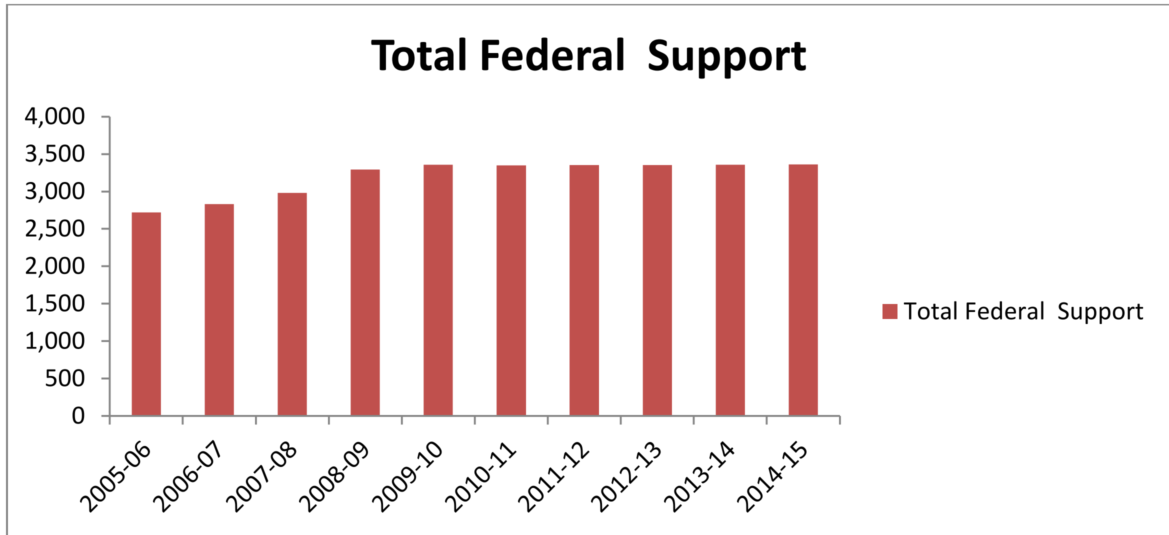
Source: Department of Finance Canada, 2005- 2015

The bar chart of Canada Health Transfer indicates that in 2005-2006, it was C$2,795 and reached C$4,184 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 1,389, which is an increase of 49.6%. The bar chart of Canada Social transfer indicates no significant change in its movement over the period of past ten years. Whereas health transfers show the higher degree of improvement as compared to social transfers. The improvement in social transfer in 2005-2006 was C$1,188 which reached to C$1,640 only in 2014-15.

MANITOBA

Manitoba evolved into a thinly populated province and its economy has been dominated by resource extraction and export, agriculture and forestry along with hydroelectricity and service-based industries. Sixty per cent of the population of the province is located in the Winnipeg, capital region, representing almost seventy per cent of the province's political economy (Thomas 2008, quoted in Inwood 2011).

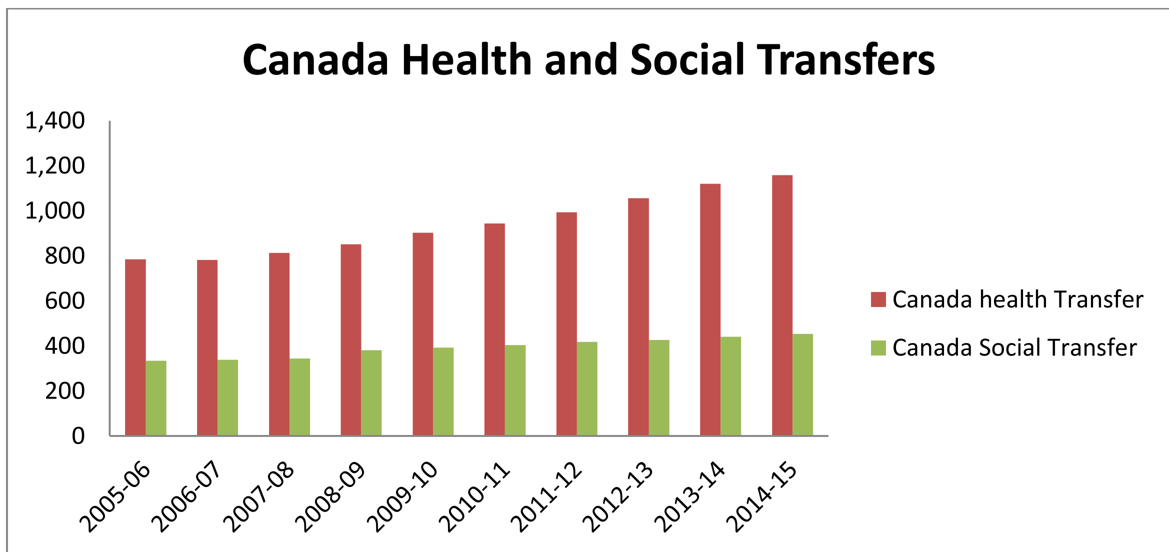
Figure5.12: Total Federal Support to Manitoba (C$ million)



Source: Department of Finance Canada, 2005-2015

The bar chart of Total Federal Support to Manitoba indicates that amount increased from 2005-06 to 2010-11 and experienced a stagnation after that till 2014 -15, in other words, it can be said that a larger proportion of the increase in total federal support was experienced in Manitoba till 2009-10. The comparison between the financial year 2005 and 2015 shows the increment of 642, which is an increase of 23.6%.

Figure 5.13: Canada Health and Social Transfers of Manitoba (C$ million)



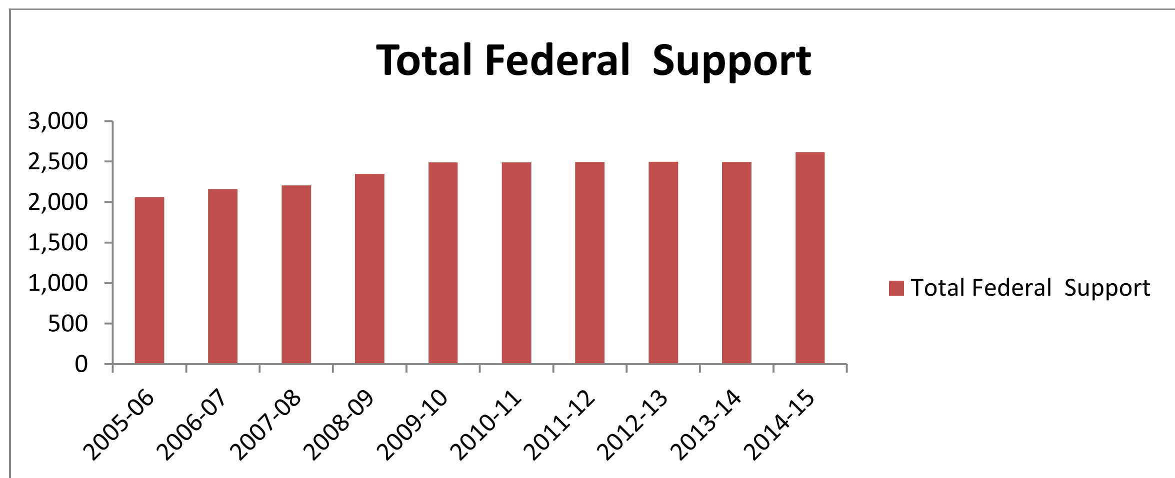
Source: Department of Finance Canada, 2005-2015

The comparison of Canada Health and Social Transfers shows that health transfers experience stagnation during the decade, whereas improved focus of the government on health transfers has helped in improving health transfers to the province continuously from C$785 in 2005-06 to C$1,158 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 373, which is an increase of 47.5%.

NEW BRUNSWICK

New Brunswick is the maritime province. The capital of the province is Fredericton. Historically, its economic base of shipping, fishing and other resources has kept its economy small. There is a rural-urban divide between the north (which is dominated by natural resources) and the south (where service-based industries prevail). Federal transfers make up forty per cent of revenue for New Brunswick (Inwood 2011).

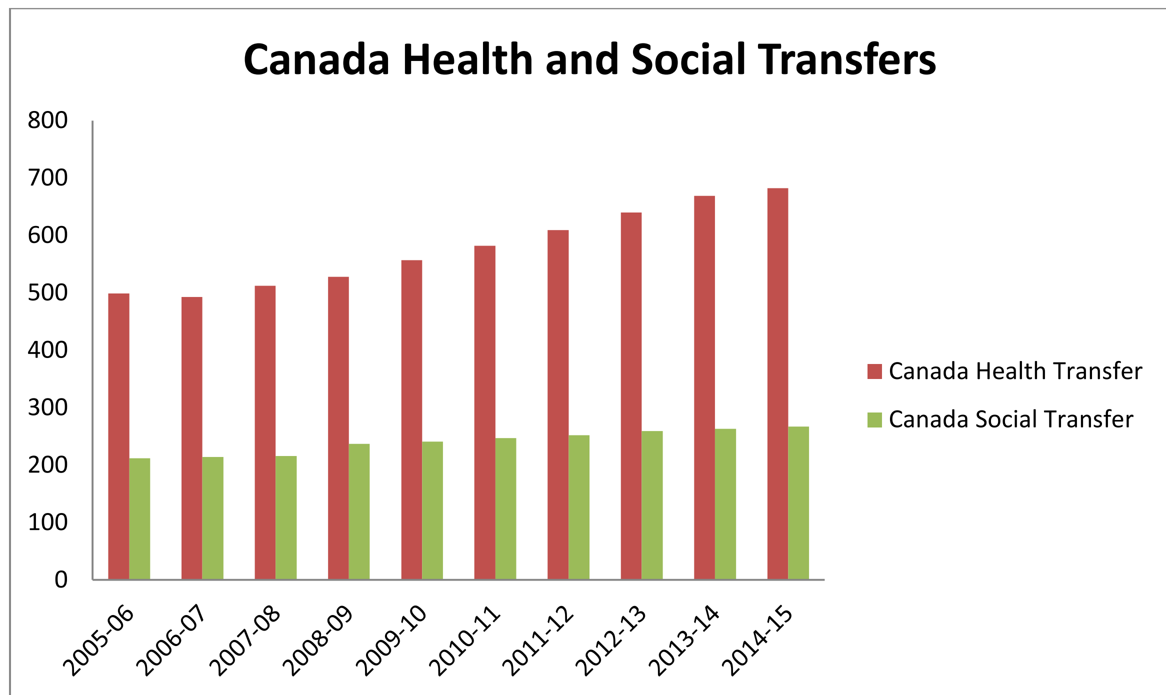
Figure 5.14: Total Federal Support to New Brunswick (C$ million)



Source: Department of Finance Canada, 2005-2015

The bar chart of Total Federal Support to New Brunswick indicates a comparable trend between Manitoba and New Brunswick, where the total transfers increased till 2009-10 and no significant improvement was experienced at the level of federal transfers after 2009-10. The comparison between the financial year 2005 and 2015 shows the increment of 716, which is an increase of 26%.

Figure 5.15: Canada Health and Social Transfers of New Brunswick (C$ million)



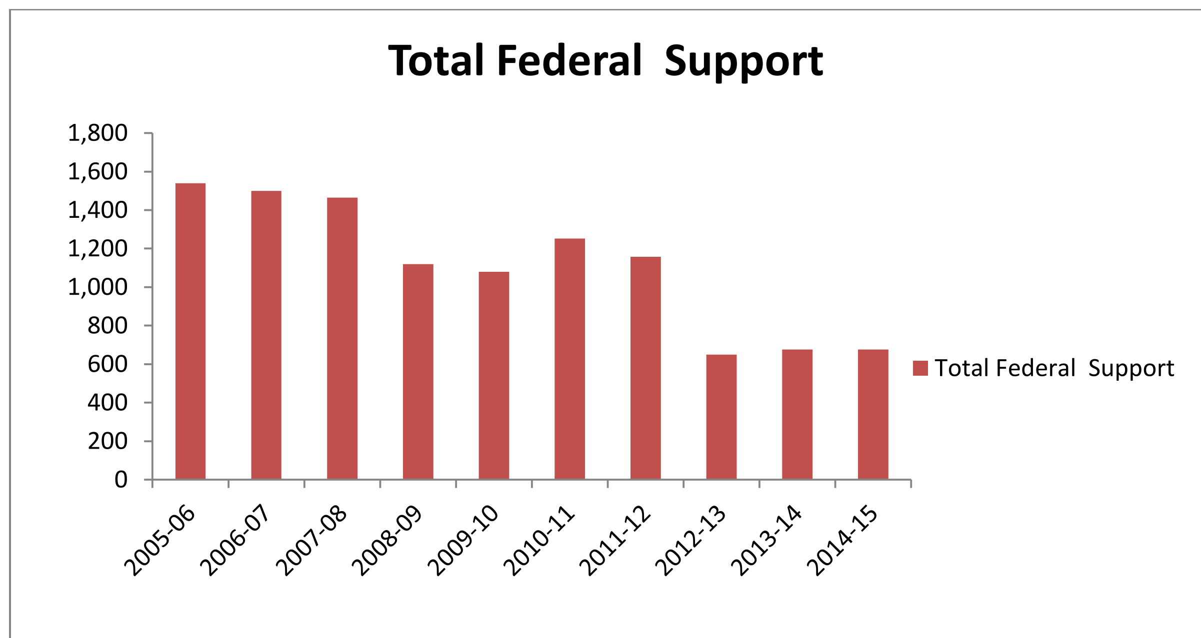
Source: Department of Finance Canada, 2005-2015

The bar chart of Canada Health Transfer indicates that in 2005-2006, the level was C$499 and increased to C$682 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 183, which is an increase of 36.6%. Like other provinces, health transfers depict a unilateral increase in the value during the year. The much lower incremental increase is shown by the Canada Social Transfer. The financial year 2005 to 2015 shows the increment of around C$55, which cannot be counted as a significant improvement over the period of ten years.

NEWFOUNDLAND AND LABRADOR

Newfoundland and Labrador is the easternmost province of Canada. Newfoundland and Labrador, also known as “the Rock”, has struggled to diversify its resource-based, seasonal economy. For most of its history, the province has been a “have-less” recipient of the federal transfers (Inwood 2011).

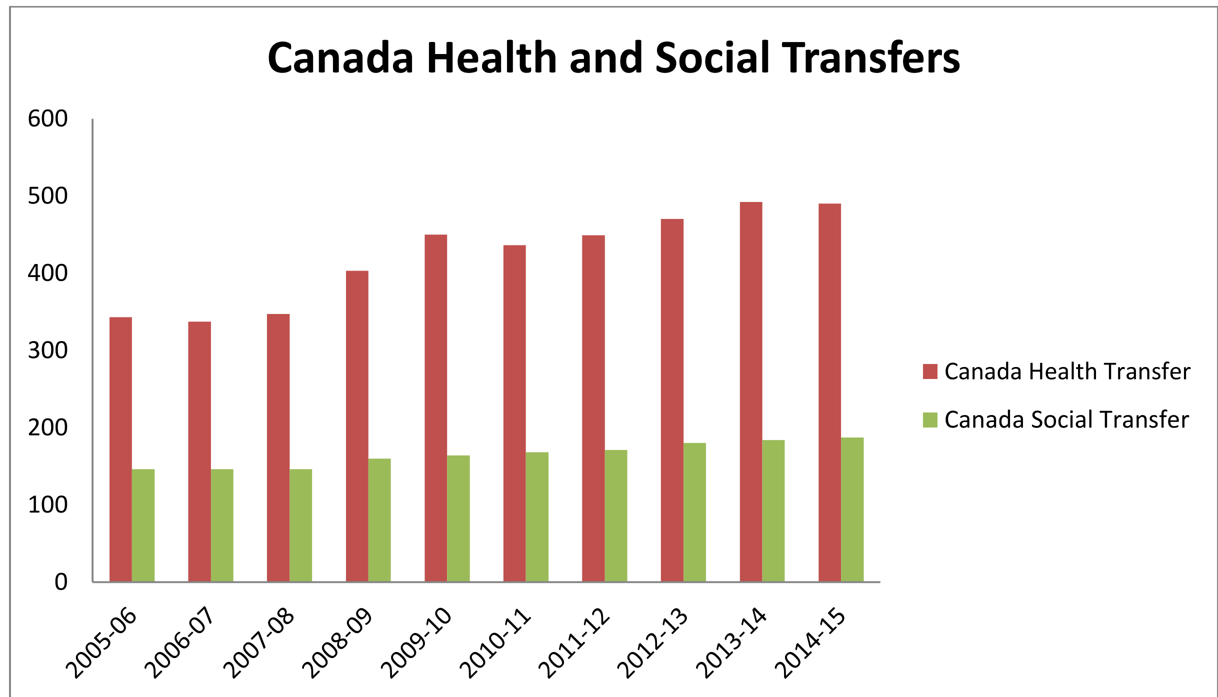
Figure5.16: Total Federal Support to Newfoundland and Labrador (C$ million)



Source: Department of Finance Canada, 2005-2015

The pictorial depiction of the Total Federal Support to Newfoundland and Labrador indicates that in 2005-2006, it was C$1,539 and declined to C$676 in 2014-2015. The comparison between the financial year 2005 and 2015 shows the decrease of C$863 in the value of total federal support, which accounts for almost 56% of the decline. This is amongst the few provinces where total federal support has declined over the decade in both values and per capita terms with high fluctuation in the entire decade in transfers of funds.

Figure 5.17: Canada Health and Social Transfers of Newfoundland and Labrador (C$ million)



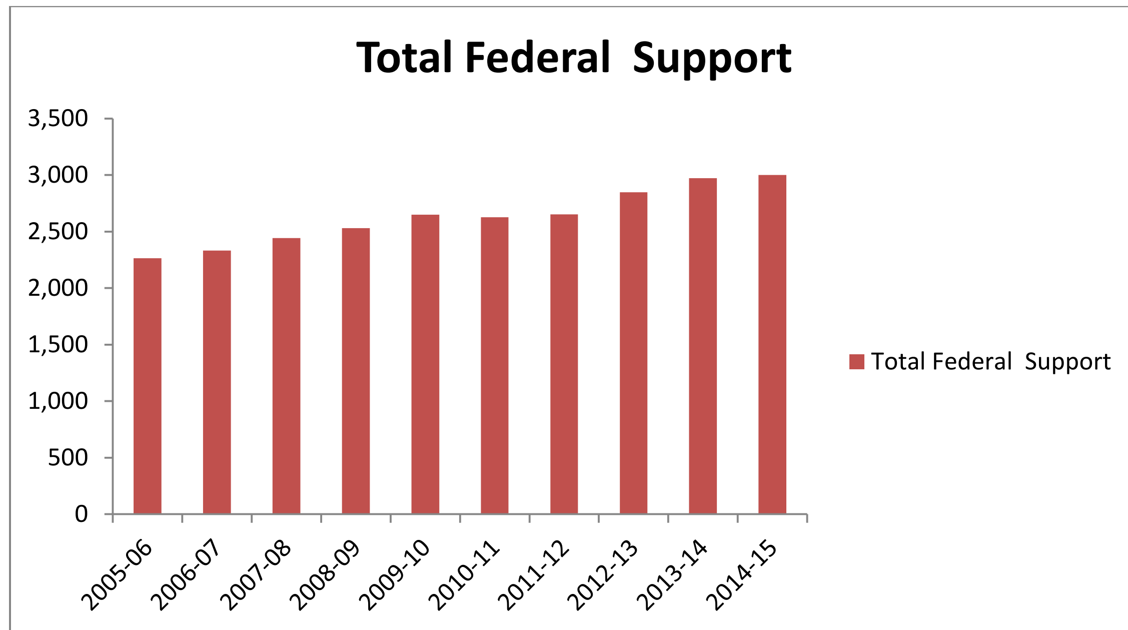
Source: Department of Finance Canada, 2005-2015

The bar chart of Canada Health Transfer and Social Transfer of Newfoundland and Labrador indicates that in 2005-2006 the value was C$343, which increased till 2009-10 and declined marginally after that till 2011-12. The comparison between the financial year 2005 and 2015 shows the increment of 147, which is an increase of 42.8%. Canada Social Transfer has not shown much movement in terms of the value of transfers by the government. The comparison between the financial year 2005 and 2015 shows the increment of 41, which is an increase of 28%.

NOVA SCOTIA

Nova Scotia is a maritime province. Halifax is a provincial capital. Nova Scotia's traditional industries include fishing, shipping, agriculture, pulp and paper, coal and steel, and grew increasingly on fiscal transfers and economic development policies from the federal government (Inwood 2011).

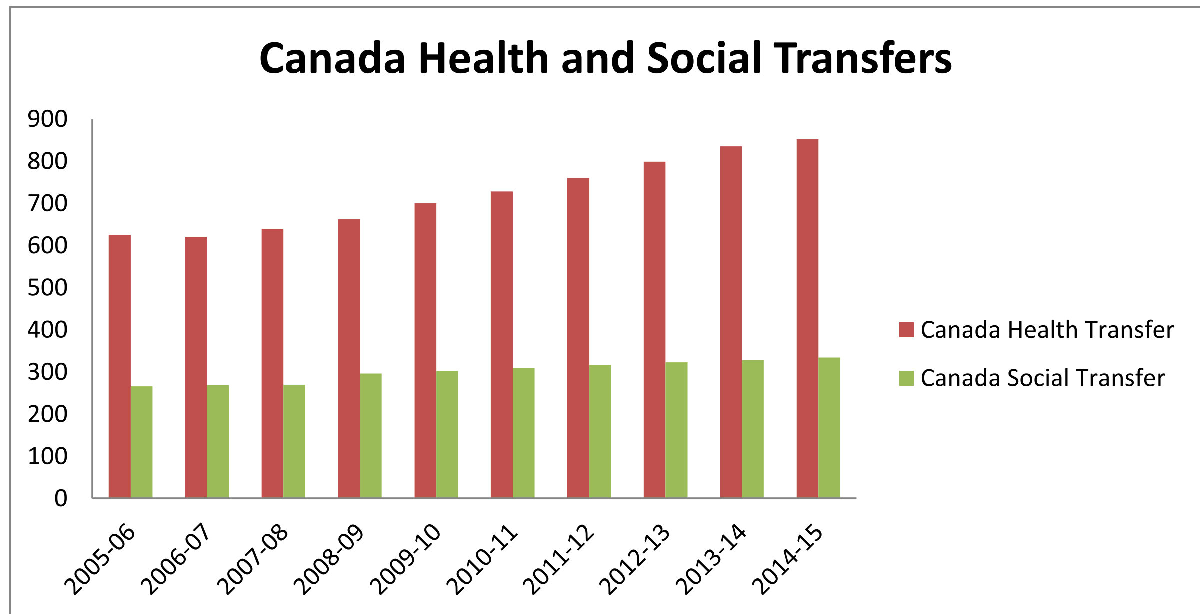
Figure 5.18: Total Federal Support to Nova Scotia (C$ million)



Source: Department of Finance Canada, 2005-2015

The data of Total Federal Support to Nova Scotia and per capita transfer shows the similar trend of continuous unidirectional increase in the value of both transfers. Total federal support was C$2,265 in 2005-06 and increased to C$3,001 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of C$736, which is an increase of 32.4%.

Figure 5. 19: Canada Health and Social Transfers of Nova Scotia (C$ million)



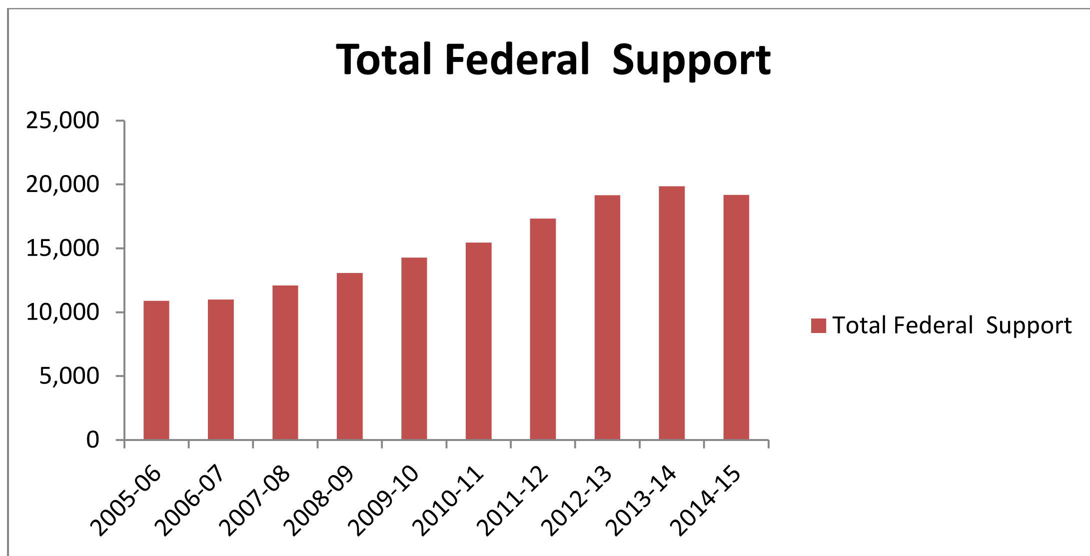
Source: Department of Finance Canada, 2005-2015

The bar chart of Canada Health Transfer indicates that in 2005-2006, the level was C$625 and increased to C$852 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 227, which is an increase of 36.3% from the initial data point. Like other provinces, health transfers depict a unilateral increase in the value during the year. The much lower incremental increase is shown by the Canada Social Transfers. The comparison over the decade (2005 to 2015) shows the increment of around C$68 only, which cannot be counted as a significant improvement over the period of a decade.

ONTARIO

Ontario is a province in the east-central portion of Canada. It is the second largest province in terms of land area and the most populous. The provincial capital is Ottawa, which is also the national capital. Toronto is the most populous city of Ontario. This province has a diversified economy, including an abundance of natural resources in the north and prime agricultural land in the south (Dyck 2009, quoted in Inwood 2011). A skilled labour force and proximity to the United States (U.S.) helped it to produce a large manufacturing sector, and the province has long led in the tertiary sector, in areas such as finances, services and the knowledge economy (Inwood 2011).

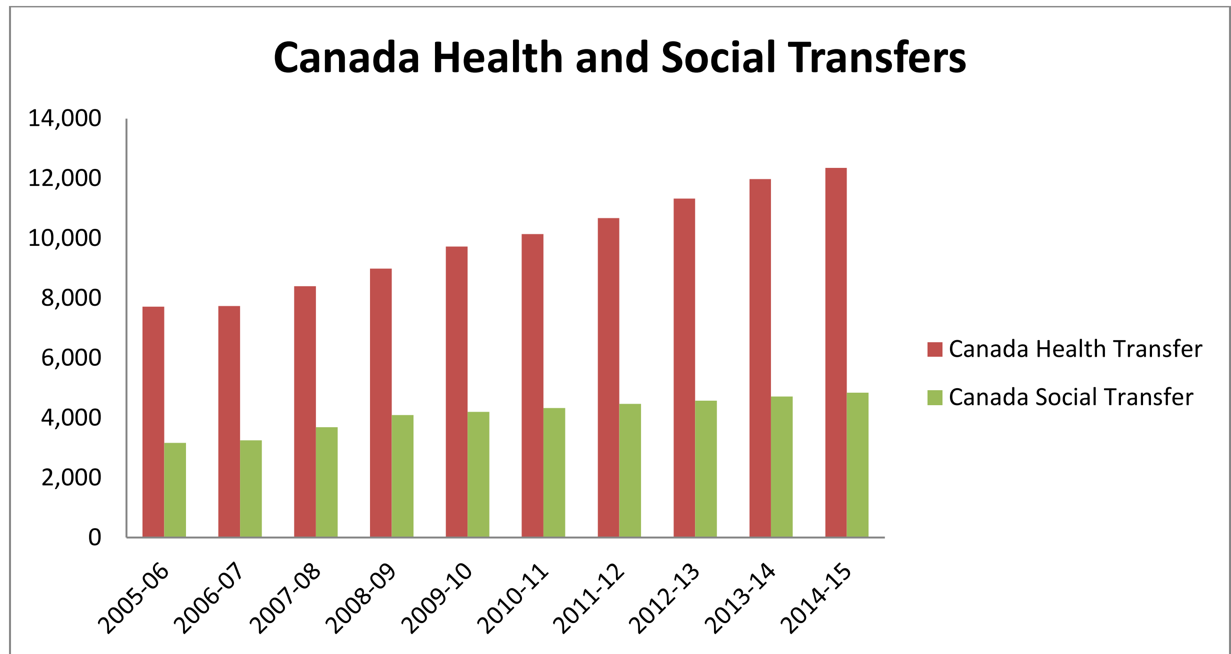
Figure 5.20: Total Federal Support to Ontario (C$ million)



Source: Department of Finance Canada, 2005-2015

The bar chart shows that the Total Federal Support to Ontario was at the value of C$10,885 in the year 2005-06 and the state experienced mild fluctuations in the transfer throughout the decade. The same variable reached at the value of C$19,187 at the end of the analysis period in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 8,302, which is an increase of 76.2%.

Figure 5.21: Canada Health and Social Transfers of Ontario (C$ million)



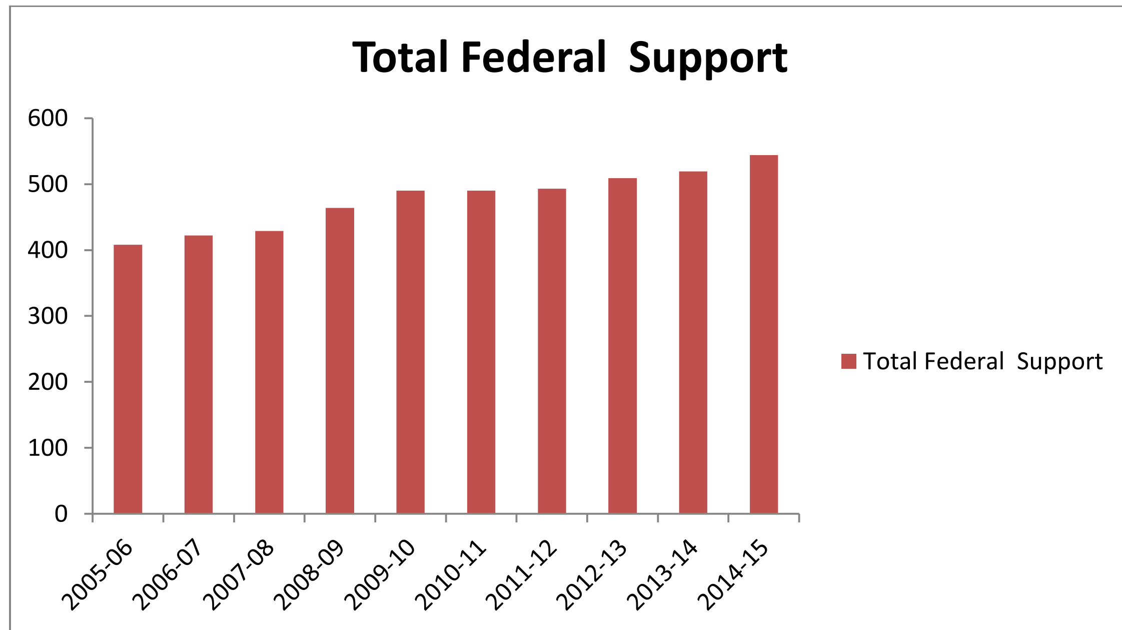
Source: Department of Finance Canada, 2005- 2015

The bar chart of Canada Health Transfer indicates that in 2005-2006, the level was C$7720, which was a high value to start with and reached to almost 12,356 after a decade on 2014-15 and increased to C$682 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 4,636, which is an increase of 60%. Like other states and provinces, social transfers depict a unilateral increase in the value during the year. The much lower incremental increase is shown by Canada Social Transfers. The comparison over the decade (2005 to 2015) shows the increment of around C$1679, which is an increase of 53% for a state with the high level of social and health transfers in 2005-06, increase of almost 53% is an achievement worth emulating.

PRINCE EDWARD ISLAND

Prince Edward Island is a maritime province and smallest and greenest province, with the lowest provincial population and a budget smaller than some of Canada's large cities. Tourism is the most viable economic prospect for the Island (Inwood 2011).

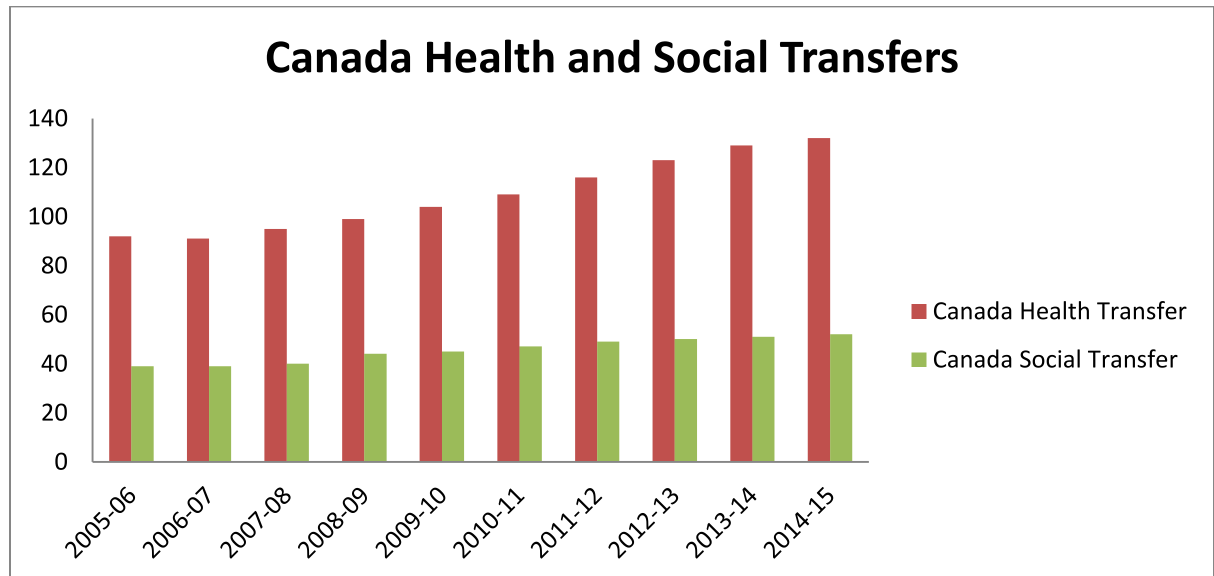
Figure 5.22: Total Federal Support to Prince Edward Island (C$ million)



Source: Department of Finance Canada, 2005- 2015

The data of Total Federal Support to Prince Edward Island and per capita transfer shows a similar trend of continuous unidirectional increase in the value of both transfers. Total federal support was C$408 in 2005-06 and increased to C$544 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 136, which is an increase of 33.3 %.

Figure 5.23: Canada Health and Social Transfers of Prince Edward Island (C$ million)



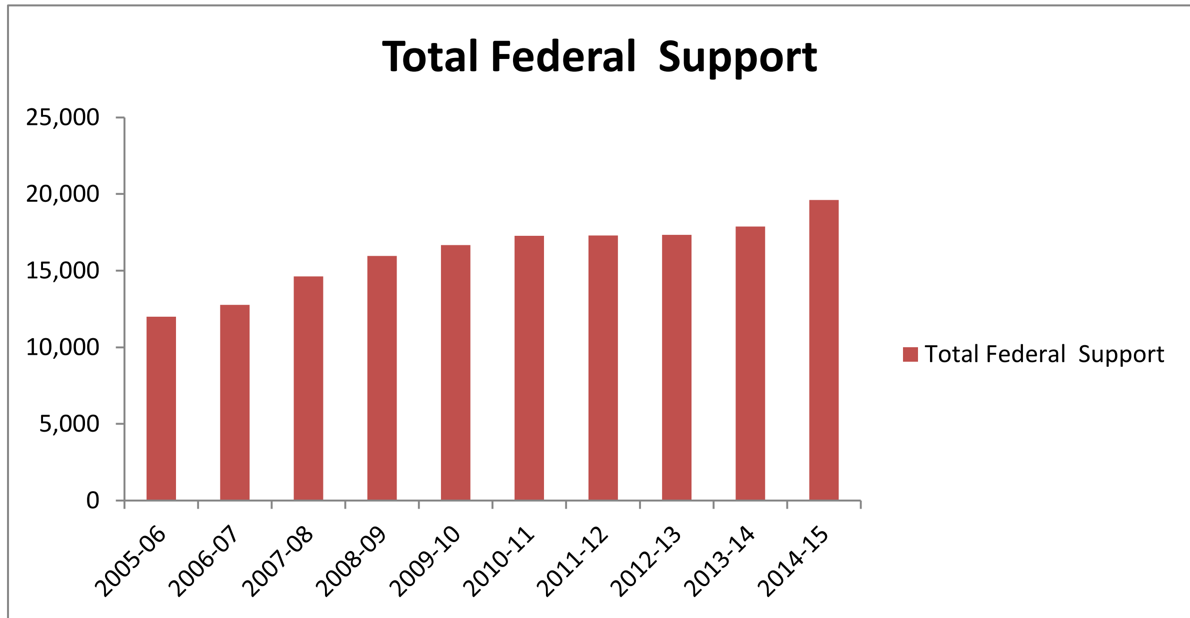
Source: Department of Finance Canada, 2005- 2015

The bar chart of Canada Health Transfer indicates that in 2005-2006, it was C$92 and C$132 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 40, which is an increase of 43.4%. The bar chart of Canada Social transfer indicates no significant change as such in its movement over the period of past ten years. Whereas health transfers show the higher degree of improvement as compared to social transfers. The improvement in social transfer in 2005-2006 was C$39, which reached to C$52 only in 2014-15, which is an increase of 30.7%.

QUEBEC

Quebec is located in east-central Canada. It is Canada's second largest province by landmass and population. It has a diversified economy grounded in natural resources, manufacturing and research, and is home to the French language and culture in North America.

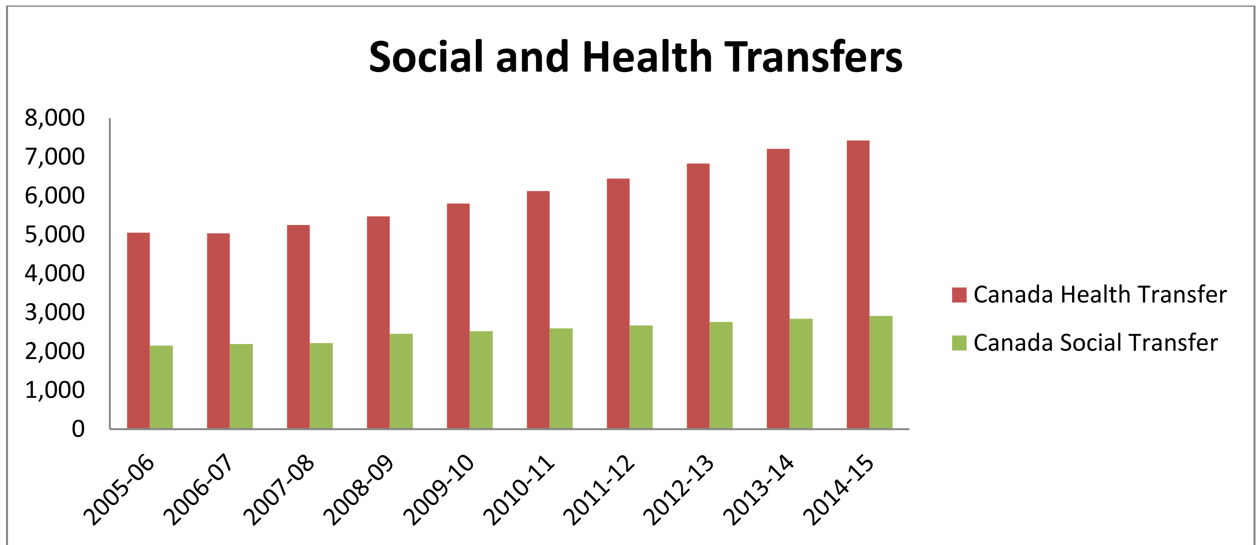
Figure 5.24: Total Federal Support to Quebec (C$ million)



Source: Department of Finance Canada, 2005-2015

The data of Total Federal Support to Quebec and per capita allocation (dollars) shows the similar trend of continuous unidirectional increase in the value of both transfers. Total federal support was C$11,993 in 2005-06 and increased to C$19,614 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 7621, which is an increase of 63.5 %.

Figure 5.25: Canada Health and Social Transfers of Quebec (C$ million)



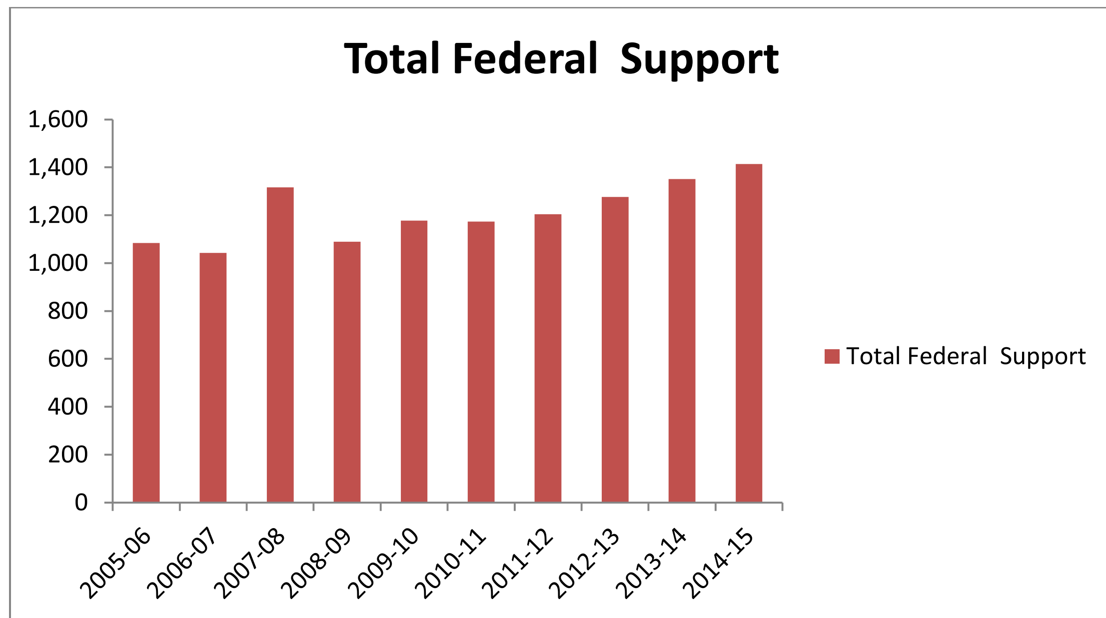
Source: Department of Finance Canada, 2005-2015

The data of Canada Health Transfer indicates that in 2005-2006, it was C$5,049 and C$7420 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 8021, which is an increase of 46.9%. The data of Canada Social transfer also indicates the significant changes in its movement over the period of past ten years. The Health Transfer shows the higher degree of improvement as compared to social transfers. The improvement in social transfer in 2005-2006 was C$2,146, which reached to C$2,908 in 2014-15 which is an increase of 35.5%.

SASKATCHEWAN

Saskatchewan is a prairie province, with a huge part of its area covered by rivers, reservoirs and lakes. The capital of the province is Regina. Agriculture, mining and energy dominate the provincial economy. Saskatchewan is also the largest exporter of potash and uranium in the world. Manufacturing and service-based sectors have also emerged in the province, although natural resources continue to dominate (Inwood 2011).

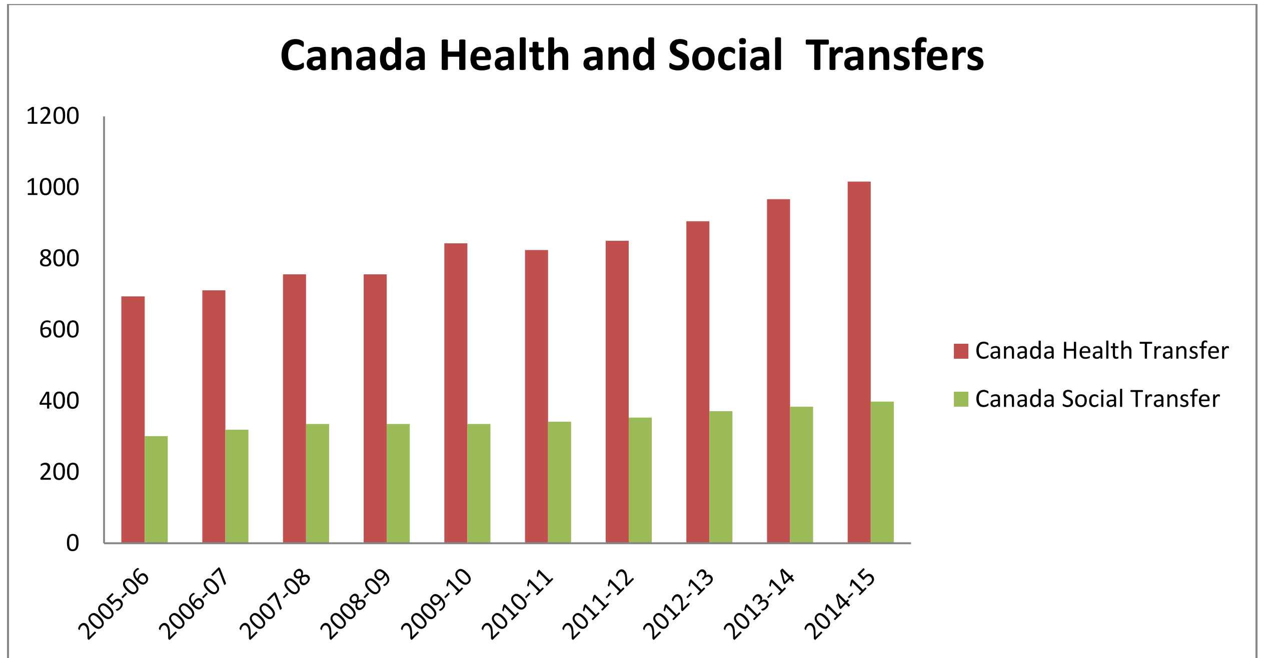
Figure 5.26: Total Federal Support to Saskatchewan (C$ million)



Source: Department of Finance Canada, 2005-2015

The bar chart of Total Federal Support to Saskatchewan indicates that in 2005-2006, it was C$1,084, which reached to C$1,351 in the year 2015, but it was not a unidirectional movement as indicated by the data. There have been fluctuations since total federal support from year to year depended on yearly budgetary policies of the federal government. The comparison between the financial year 2005 and 2015 shows the increment of 330, which is an increase of 30.4%.

Figure 5.27: Canada Health and Social Transfers of Saskatchewan (C$ million)



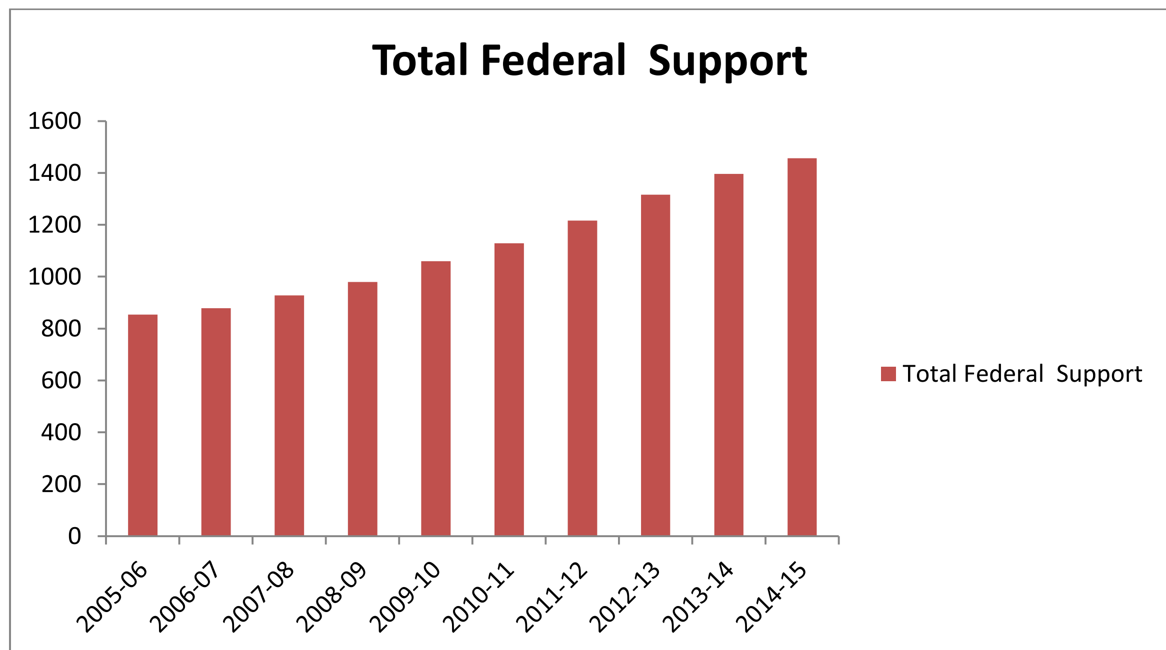
Source: Department of Finance Canada, 2005-2015

The bar chart of Canada Health Transfer indicates that in 2005-2006, the level was C$499 and increased to C$682 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 322, which is an increase of 46.3%. The much lower incremental increase is shown by Canada Social Transfer. The financial year 2005 to 2015 shows the increment of around 330, which is an increase of 30.4%, which cannot be counted as a significant improvement over the period of 10 years.

NUNAVUT

Nunavut is the most recently created territory, established in 1999, by the Nunavut Land Claim Agreement (NLCA*)* whereby the Inuit received title to 350,000 square kilometres of land, their right to harvest wildlife in Nunavut and C$1.173 billion over fourteen years, in exchange for relinquishing alternative Aboriginal claims. Except for a small portion that would flow to Inuit claimants in Nunavut, revenue from natural resources belongs to the federal government (Inwood 2011).

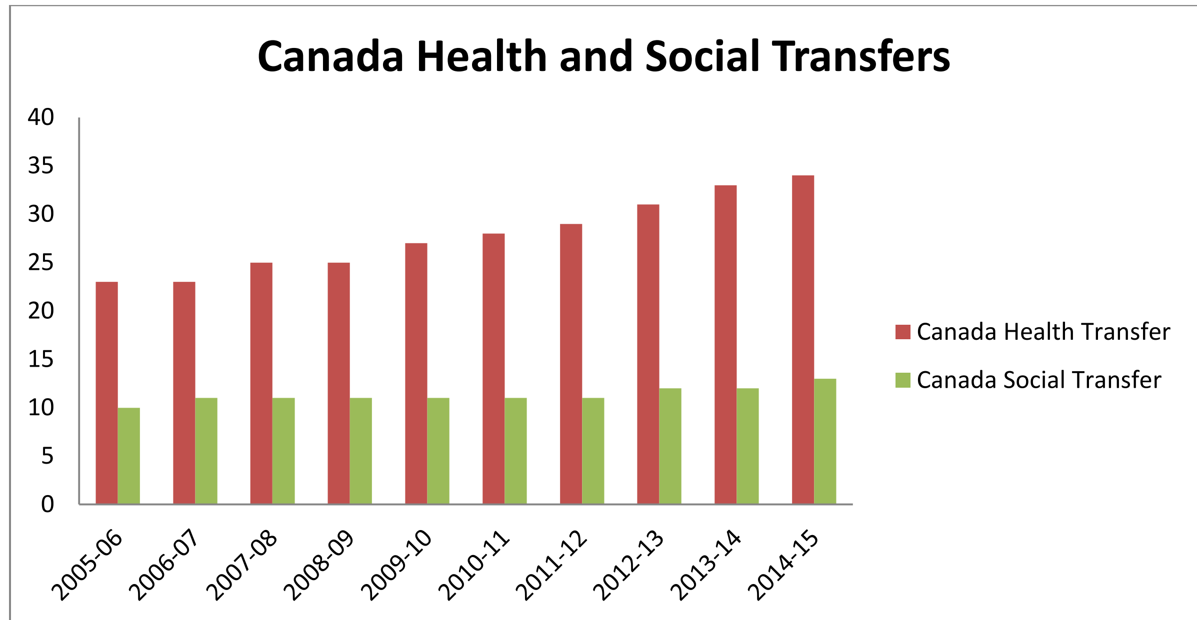
Figure 5.28: Total Federal Support to Nunavut (C$ million)



Source: Department of Finance Canada, 2005-2015

The diagram depicts the improvement in total federal support by the Canadian Government in the decade, which is marked by improved focus of the government on transfers. The comparison between the financial year 2005 and 2015 shows the increment of 602, which is an increase of almost 70.4%.

Figure 5.29: Canada Health and Social Transfers of Nunavut (C$ million)



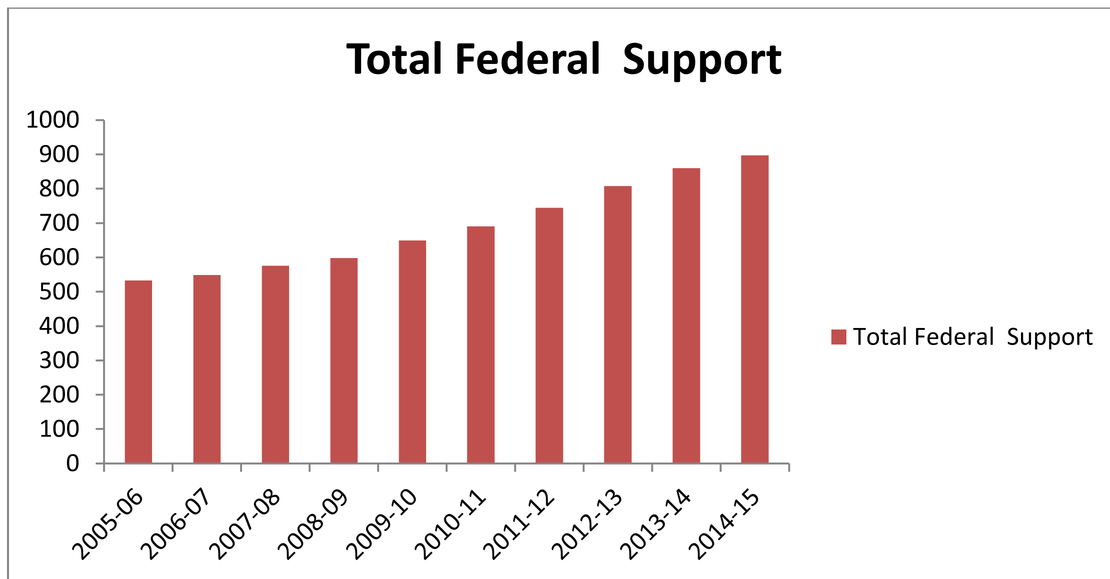
Source: Department of Finance Canada, 2005-2015

The data of Canada Health Transfer indicates that in 2005-2006, it was C$23 and C$34 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 11, which is an increase of 47.8%. The data of Canada Social Transfer also indicates slight changes in its movement over the period of past ten years. The health transfer shows the higher degree of improvement as compared to social transfer. The improvement in social transfer in 2005-2006 was C$10, which reached to C$13 in 2014-15, which is an increase of 30%.

YUKON

Since its creation as a territory of Canada in 1898 by the Yukon Act, its borders have never been altered unlike the Northwest Territories.

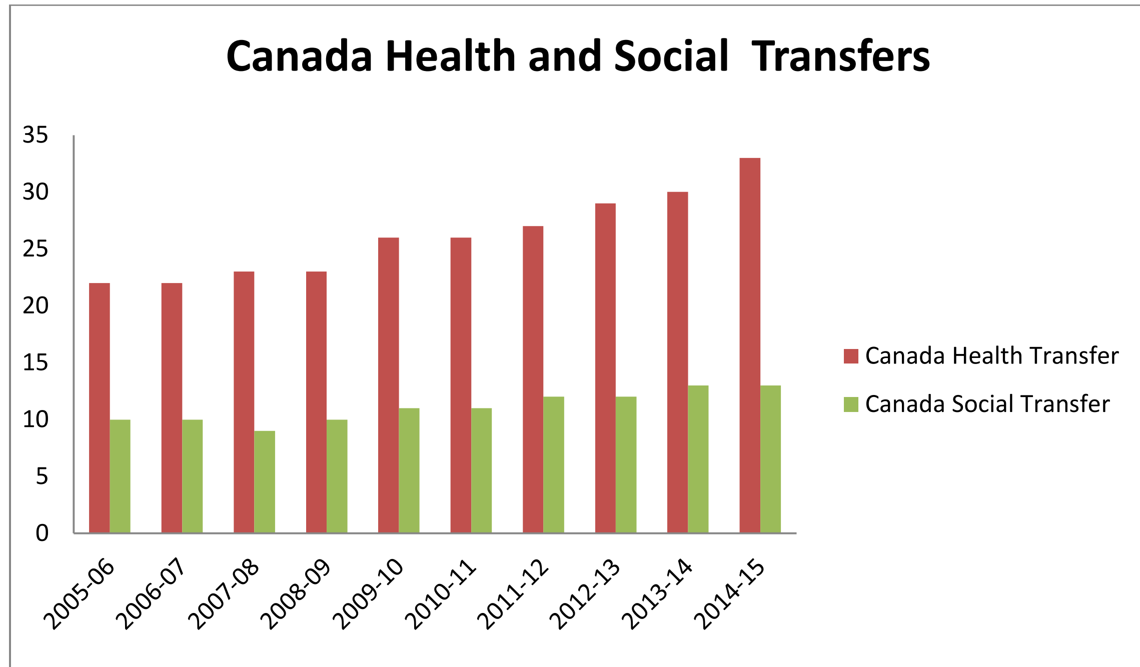
Figure 5.30: Total Federal Support to Yukon (C$ million)



Source: Department of Finance Canada, 2005-2015

The diagram depicts the improvement in total federal support by the Canadian Government in the decade, which is marked by improved focus of the government on transfers. The comparison between the financial year 2005 and 2015 shows the increment of 364, which is an increase of almost 68.2%.

Figure 5.31: Canada Health and Social Transfers of Yukon (C$ million)



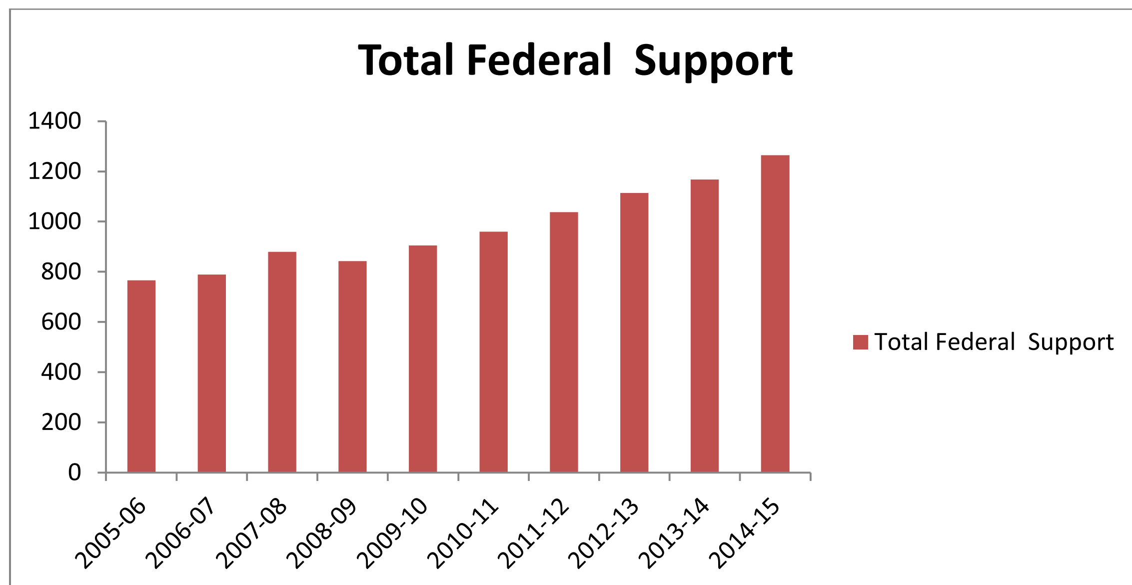
Source: Department of Finance Canada, 2005-2015

The bar chart of Canada Health Transfer indicates that in 2005-2006, it was C$22 and C$33 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 11, which is an increase of 50%. The bar chart of Canada Social Transfer indicates significant changes in its movement over the period of past ten decades. Whereas health transfers show the higher degree of improvement as compared to social transfers.

NORTHWEST TERRITORIES

This has abundant natural resources, a sparse, a young population with a high birth rate and an Aboriginal population of approximately half of the total population. The Northwest Territories were officially admitted as a territorial jurisdiction within Canada in 1869 with the Northwest Territories Act. Its borders were redrawn and overall area reduced significantly several times, most recently in 1999 when the territory of Nunavut was created (Inwood 2011).

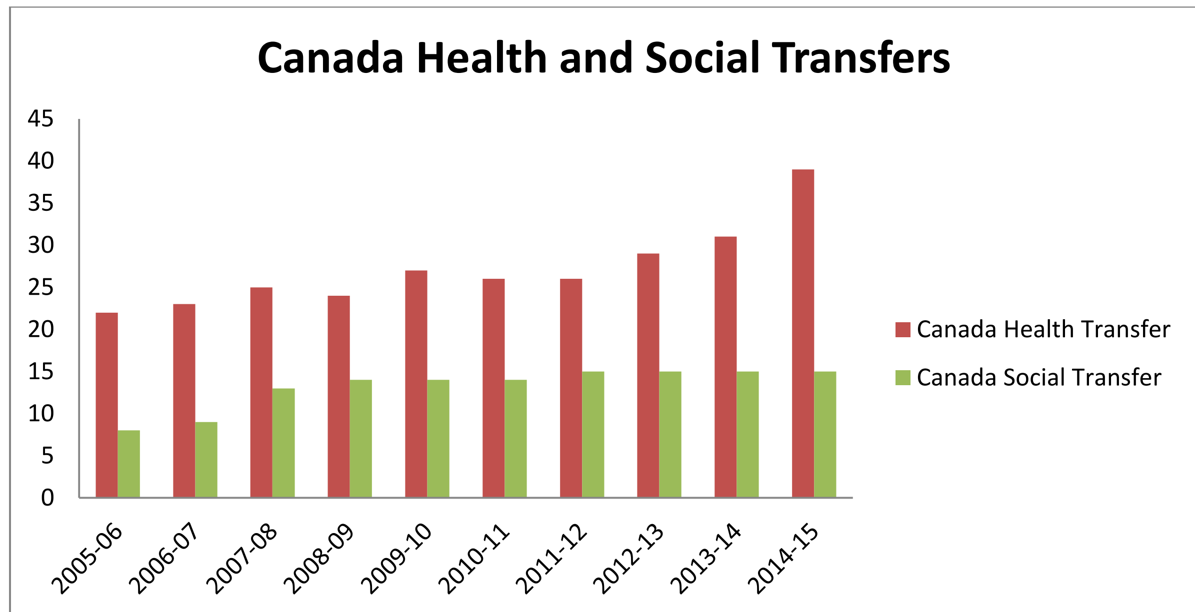
Figure 5.32: Total Federal Support to Northwest Territories (C$ million)



Source: Department of Finance Canada, 2005-2015

The diagram depicts the improvement in total federal support by the Canadian Government in the decade, which is marked by improved focus of the government on transfers. The comparison between the financial year 2005 and 2015 shows the increment of 498, which is an increase of almost 65%.

Figure 5.33: Canada Health and Social Transfers of Northwest Territories (C$ million)



Source: Department of Finance Canada, 2005-2015

The bar chart of Canada Health Transfer indicates that in 2005-2006, the level was C$22 and increased to C$39 in 2014-15. The comparison between the financial year 2005 and 2015 shows the increment of 17, which is an increase of 77.2%. The bar chart of Social Transfer indicates the increment of around C$7 from 2005 to 2015, which can be counted as a significant improvement over the period of 10 years in Canada.

Thus, the Chapter attempted to analyse Total Federal Support, Health and Social Transfers of ten provinces and three territories of Canada within the span of a decade i.e., from 2005 to 2015. It finds that there is an increase in Total Federal Support, Per Capita Allocation (Dollars), Health and Social Transfers in all the provinces and territories, while Newfoundland and Labrador is the only exceptional province. There is no uniform pattern in the numerical and percentage growth of data. The Total Federal Support and Per Capita Allocation (Dollars) show the decrease in terms of number and percentage, while Health and Social Transfers show an increase in terms of number and percentage in the case of Newfoundland and Labrador.

Conclusion

Intergovernmental transfers are an important source of revenue for both the provincial and territorial governments and an important expenditure item for the federal government. What is interesting about these trends of health expenditures is the rate at which they grew over the last ten years that has varied substantially across the ten provinces and three territories. The period starting from 2005 to 2015, for the ten provinces and three territories, shows that average growth has been the highest in Newfoundland and Labrador. The growth rates are highest in the Atlantic provinces of Newfoundland and Labrador, New Brunswick and Nova Scotia. While demographic and environmental factors across the provinces can account for some of these differences, the provinces may also have some very different approaches to their healthcare systems when it comes to providing and managing healthcare. Some of the rich/economically advanced provinces have been allocated the larger amount for healthcare compared to their resource scarce counterparts. The transfer regime shifts variables also provide some interesting information on the impact of policy changes in transfer payments over the time, besides from changes in the amount/monetary value of transfers. Interestingly enough, the onset of the CHST also seems to have a positive and significant effect on the public healthcare system, which is shown in the regression result. This suggests that transfer regime shifts may have sparked a search by the provincial governments for more cost effective ways of delivering hospital and physician services through a broader approach to health, such as public health or other health approaches.

Sustainability of provincial government health spending requires that expenditures increases on health match or fall below increases in measures of the resource base. The general solutions require either increased resources via taxes or user fees, outright expenditure and service cuts, restructuring and reforms for internal efficiencies or simply moving some provincial government health expenditures to the private sector.

The federal power of accountability, for how provincial and territorial governments spend transferred funds, has evolved along with fiscal arrangements over the years; and this is a ticklish issue as fiscal transfers come with ‘conditionalities’ or in the form of specific, targeted programmes. In the 1950s and 60s, federal transfers were ‘conditional’ cost-

sharing grants that encouraged the establishment of national programmes (Department of Finance Canada). One needs to understand that over the years, health and social transfer payments have developed from cost-sharing programmes to block funding transfers. Each year, the federal government gives the provinces billions of dollars to support the delivery of provincial health services and programmes. The federal government regularly places 'conditionalities' on the provinces in conjunction with these funds. A province may choose to refuse the federal funding and the 'conditions' that come with it. However, most provinces are highly dependent upon Ottawa for healthcare support and simply cannot afford to forgo these funds.

Is a provincial government health spending in Canada fiscally sustainable? When the regression result was examined, the conclusion is that it depends on a number of factors. It depends on economic growth and its effect on federal health transfer. It depends on the policy response to cost increases and technological change, as evident in the effect of the time trend variable. It depends on age. It depends on the level of provincial debt and the resources required servicing that debt. It depends on which province a person lives in. The current preference of people for private healthcare providers is evident, but it has not discouraged citizens from registering themselves for the public healthcare system as well. The number of registered persons in public healthcare system has grown over the last ten years substantially and this number has responded positively to improved services in public healthcare like the increasing number of doctors, improvement in healthcare facilities etc. Thus, it can be concluded that though delay in provision of services in public healthcare is pushing people towards private services, but even now Canadian citizen would like themselves to get registered with public healthcare system, which is financed through the taxes paid by them.

The next Chapter 'Summary and Conclusions' will connect all the dots regarding healthcare system of Canada. It will analyse the policies, intergovernmental agreements, mechanisms, fiscal provisions and quantative analysis associated with it together to derive conclusion regarding relevance, efficiency and shortcomings of the Canadian healthcare system.

CHAPTER VI
SUMMARY AND CONCLUSIONS

The preceding Chapters described and analysed the ways in which intergovernmental relations (IGR) have evolved over the years in the Canadian healthcare system. The federal 'spending power' and its execution remains a primary determent of revitalisation of intergovernmental relations. The Social Union Framework Agreement (SUFA) brought greater collaboration between federal, provincial and territorial governments in the area of healthcare.

The genesis of federal 'spending power' can be traced back to SUFA where the collaborative nature of the Canadian federalism was transformed in consultation with all provinces and territories except Quebec. The SUFA tried to incorporate challenges faced by the Canadian system in both vertical and horizontal transfers. It analysed the non-uniformity of provinces and their unique challenges and limitations in effective implementation of the Canada Health Act (CHA). The challenges stem mainly from differentiated economic and geographical background of the provinces and territories.

This revitalisation has made federal relations 'collaborative' in nature to the extent that SUFA allowed by higher degree of consultation among the provinces and Ottawa. The reductions in fiscal transfers need to be pre announced to the provinces and the perspective changes in policies need to be consulted with the provinces. The consent of provinces in policy matter enhances the level of autonomy enjoyed by the provinces in pre SUFA era.

Though the power of spending is in the hands of the federal government, high degree of consultation amongst the different tiers of governance leads to higher decentralisation and high degree of collaborative federalism in the healthcare sector as well as competitiveness in nature between provinces due to foreign direct investment (FDI).

It is evident from the literature review that IGR in healthcare in Canada have been recurring consensus of researchers, policy planners and academics. However, the focus of the research study has been the period of fifteen years from 1999 to 2014.The study also

prepared the ground for the understanding of IGR in Canada in the overall context of federalism including health expenditures over the period of 2005 to 2015. The models of federalism from cooperative to collaborative federalism from the IGR perspective did emerge in Canada during different political and economic phases. Significantly, each model of federalism generated its own decision-rules and the level of intergovernmental consensus required for a decision and each model also has had different implications for policy outcomes. The result of these developments in the policy space of intergovernmental transfers is a complex system of finance and implementation of health related policies and initiatives in the country. Though, the primary responsibility of healthcare provision lies with the provinces, the onus of financing these services lies with the federal government. This system gave way to financial and other conflicts among the federal and provincial governments which were also political in nature, at time differences in political regime at federal and provincial level lead to this conflict. The current system provides greater ability to rich states or to states which can generate higher tax revenues to provide efficient and better quality healthcare facilities to their residents. Resource scarce provinces are resorting to cost sharing methods to manage the changes in funding sources introduced through CHA.

The work has focussed on understanding the CHA of 1984. The importance of intergovernmental resources in healthcare policy can be ascertained from the changes in the pattern of healthcare provision services which were in sync with changes in policy decisions. It can be concluded that the intergovernmental relations in the healthcare system in Canada are collaborative in nature. The changing policies of the government and the shifting focus of policy makers have changed the way in which the collaboration has evolved over the decades, but it has not changed the requirement of synergy which is needed between different layers of governance to successfully deliver social services in Canada.

The use of regression analysis is justified in this study because the study aims at identifying the causal relationship between the number of registered persons in the healthcare system and various other policy variables taken as an independent variable (the number of hospitals, the number of doctors, etc.). The regression analysis is used for

determining whether changes in the policy variables like the number of hospitals, the number of doctors and state expenditure on healthcare system have a statistically significant impact on the number of registered persons in the Canadian healthcare system. This analysis will help in identifying as well as measuring the efficacy of the Canadian healthcare system constituted under the CHA. This analysis is used for quantitatively identifying the impact of changes in the CHA on the healthcare system. Descriptive analysis is used mainly for identifying trends in the variables, whereas regression provides a larger scope of in depth analysis and interdependence among variables. The time period chosen for the analysis is 1999 to 2104 to clearly depict the impact of changes in the CHA which was initiated in 1999-2000 and further modified in the year 2004-2005 through the bifurcation of the Canada Health and Social Transfer (CHST) into the Canada Health Transfer (CHT) and Canada Social Transfer (CST). As social policies show impact with longer gestation period, the data frame is expanded to the year 2014-2015.

The healthcare challenges today are different from those that were there when the CHA of 1984 was designed. The regression and quantitative analysis have depicted how in some state the preference of the people has shifted from public to private provisions of health services. Though, the number of registered persons has increased in the period from 1999-2000 to 2014-2015 but this increase is not uniform across all states. The major components responsible for this increase are mainly connected to infrastructural facilities provided in the provinces like the number of doctors, the number of hospitals and the number of dentists in these provinces along with a corpus of funds received from the federal government specifically for the provision of healthcare services.

The bifurcation of total federal transfers into health and social sector transfers has changed the way in which these services are funded at the provincial level. Now, the payments are primarily sourced from provincial funds and to deal with the excess burden on the fiscal condition of the provinces, new methods are being evolved at decentralised level. It has led to comparatively greater reliance on the private sector. The shortage of infrastructure in this sector has led to long waiting durations for the patients, which has emerged as a major concern for the provinces.

The SUFA is a milestone in the healthcare policy making of Canada mainly because the bifurcation of healthcare transfer was achieved only after the recommendation of Romanow Report which followed the SUFA agreement. In preparation for the 2004 Health Accord, two major reviews of the health system were conducted: the Royal Commission Report, commonly known as the Romanow Report of 2002, and the earlier Kirby Report which was a Senate report. The Kirby Report was released in October 2002. Chaired by Liberal Senator Michael Kirby, it endorsed the concept of private provision of healthcare. The report also proposed expanding public responsibility and funding into new areas of healthcare such as home care and pharmaceuticals. The Romanow report is more expansionary and an endorsement of the principles enshrined in the CHA and the strong attachment Canadians have to their Medicare. Some of Romanow Report's recommendations were adopted when the Health Council of Canada and CHT were established. Québec remains unexceptional to the collaborative nature of healthcare policy in Canada mainly because of its non-participation in SUFA and later on its objection to privatisation of healthcare facilities as highlighted by Chaoulli's judgement.

The federal 'spending power' on healthcare from the period of 2005 to 2015.Interesting about these health expenditure trends is the rate at which it grew over the last ten years that has varied substantially across the ten provinces and three territories. The period from 2005-2015 for the ten provinces and three territories shows that the average growth has been highest in Newfoundland and Labrador. And the growth rates are highest in the Atlantic provinces of Newfoundland and Labrador, New Brunswick and Nova Scotia. While demographic and environmental factors across the provinces can account for some of these differences, the provinces may also have some very different approaches to their healthcare systems when it comes to providing and managing healthcare. Some of the economically advanced provinces have been allocated the larger amount for healthcare compared to their resource scarce counterparts. The transfer regime shift variables also provide some interesting information on the impact of policy changes in transfer payments over time besides from changes in the amount/monetary value of transfers. Interesting enough, the onset of the CHST also seems to have had a positive and significant effect on the public health system which is shown in the regression result. This suggests that transfer regime shifts may have sparked a search by the provincial

governments for more cost effective ways of delivering hospital and physician services through a broader approach to health such as public health or other health approaches.

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Is a provincial government health spending in Canada fiscally sustainable? When the regression result was examined, the conclusion is that it depends on a number of factors. It depends on the economic growth and its effect on federal health transfer. It depends on the policy response to cost increases and technological change as evident in the effect of the time trend variable. It depends on age. It depends on the level of provincial debt and the resources required servicing that debt. It depends on which province a person lives in. The current preference of people for private healthcare provisions is evident, but it has not discouraged citizens from registering themselves for the public healthcare system as well. The number of registered persons in public healthcare system has grown over the last ten years substantially and this number has responded positively to improved services

in public healthcare like the increasing number of doctors and improvement in healthcare facilities etc. We can conclude that though delay in provision of services in public healthcare is pushing people towards private services but even now the Canadian citizens would like to get themselves registered with public healthcare system which is financed through the taxes paid by them.

One needs to understand why this SUFA agreement came up in 1999. In the 1980s and 90s,there were lots of federal cuts in social transfers to the provinces as the federal government was fighting its own fiscal deficit and debts besides it had to comply with the provisions of Canada-United States Free Trade Agreement (CUSFTA) and North American Free Trade Agreement (NAFTA) in removing fiscal support and subsidies. Looking back, the creation of the CHST in 1995 and subsequent deletion of the Established Programmes Financing (EPF) and Canada Assistance Plan (CAP) shook federal-provincial relations. The perception that Ottawa was unilaterally changing the face of the social policy landscape upset the provinces as it burdened them with extra financial responsibilities. Former Saskatchewan Premier Roy Romanow suggested that such unilateral actions had endangered the social union because Ottawa had ignored the balances of federalism and the constitutional division of powers. In the 1995 budget, the federal government unilaterally imposed a C$6 billion cutback in transfers to the provinces for healthcare, post-secondary education, and social services. The provinces responded to federal cost-containment measures and unilateral cuts in transfers, especially those found in the 1996-97 federal budget, with a restructuring of federalism which would focus mainly on renewing social policy through more collaborative federal-provincial relations. The result of these discussions was the SUFA agreement. SUFA was signed in February 1999 by the federal government, nine provinces and the territories. Only the Quebec government refused to sign SUFA. It grew out of a concern to limit the federal 'spending power' in the areas of exclusive provincial jurisdiction, ensure stable and sustainable funding for social programmes like health, post-secondary education, transparency and public accountability, and manage intergovernmental disputes.

Lots of constraints on the future use of the federal ‘spending power’, an unsustainable rate of increase in healthcare costs, and the demographic challenges are posed by an aging population and interstate migration. The percentage of elderly population is increasing in Canada every decade, which has increased the proportionate burden on the healthcare services. Canada is spending more on Healthcare (14%) than the National Defence (8%) which is mentioned in the Figure 5.1.It is because of the concern of the aging population of Canada. This phenomenon is comparable to Japan and Sweden and requires higher fiscal provision from the government to services required for elderly care and healthcare constitute as substantial part of it.

One major findings is that in the period of 1999, there is also emerging challenges in the area of public health. Issues involved in the sphere of public health differ from personal and individualised healthcare schemes and programmes. Threats in the area of public health are enormous, sudden and beyond jurisdictional debate – all requiring immediate and effective intergovernmental responses; at times, even trans-border and trans-national response. The failure to manage public health threats by one government can create a risk for others. Coordinating policies between the orders of government are a necessary central element for an effective public health system.

There are three related events, each led to varying degree of changes in the Canadian approach to preparing for and managing public health emergencies, particularly at the federal level:

(i) In 1999, the Auditor General stated that the effects of globalisation on disease migration require public health concerns. For this, it required advanced processes and institutions to manage intergovernmental and intragovernmental cooperation.

(ii) The terrorist attacks on the World Trade Centre in New York City in September 2001 suddenly found Canada hosting thousands of flights and passengers amidst threats of attacks in Canada too. The fear of future attacks of this nature led to a complete rethinking of Canada’s approach to national security. In the immediate aftermath of the attacks, Health Canada quickly expanded the National Emergency Stockpile System to respond to the

increased need for various pharmaceuticals to treat and protect Canadians from chemical agents like anthrax and from infectious diseases such as small pox. In October 2001, the federal-provincial/territorial Deputy Ministers of Health created the Special Task Force on Emergency Preparedness and Response and charged it with developing recommendations on how best to prepare the country for any kind of possible health emergency.

(iii) The third event to reshape the debate in Canada on the national public health system was the outbreak of Severe Acute Respiratory Syndrome (SARS), commonly called 'bird flu'. It first appeared in China in 2002 and spread to Canada, where the first case arrived in Toronto in 2003. A single Canadian returning from a trip to Asia, eventually sparked an outbreak that affected 438individuals and resulted in 44 deaths and a travel advisory for the city of Toronto issued by the World Health Organisation. Managing the spread of SARS presented a considerable challenge to all orders of government. It was the portent of epidemic-like spread of diseases which called for immediate serious steps in the area of public health which eventually led to the creation of the Public Health Agency of Canada in 2004 and the appointment of its first Chief Public Health Officer (MacLennan 2008).

One needs to understand that intergovernmental 'collaboration' is needed not only in the area of healthcare but also in the area of emerging issues related to public health.

The healthcare system has improved slightly in the recent years, but on the whole, the system remains somewhat unsustainable and urgently in need of substantive change. The Canadians have more confidence in their provincial than the federal government to make positive changes in the future. The federal government could transfer more money to the provinces; of course, with conditions. There remains strong support and the need for national standards in healthcare provision. The highest policy priority for Canadians is timely access to care. The quality is also a major concern. There is an increasing attention to private sector provisions of healthcare service as well, in large part a response to the expectations about the quality of public services. Most people interested in private

healthcare view this as an addition to, rather than a replacement for, the public healthcare system.

The ten year plan had expired in 2014. The question of renewal of the healthcare agreements with the provinces and territories remains unresolved. In the state of this political uncertainty about healthcare policies and financial distribution of health services, the quality of these services has continuously declined. Moreover, the average wait is on rise for patients even with illness and diseases which require timely medical intervention. People are shifting their preference from public to private sector, which costs more and hence reduces the overall welfare of the society.

For improvement in the efficiency of healthcare services, scholars have suggested:

(i) Higher improvement in infrastructure so as to improve healthcare services, and (ii) to increase the average number of hospitals, doctors and beds so as to reduce waiting time.

Analyses have even supported access to the external sources of funding. It is argued that the government needs to provide an attractive opportunity is FDI in healthcare sector so as to augment infrastructural development in this area. Better monitoring of public healthcare system by government machinery may also be used as a method of enhancing efficiency of healthcare system. Healthcare is a state subject; then more autonomy should be provided to the provinces and territories for the implementation of CHA. This autonomy will be effective only when appropriate finances are provided to the provinces and territories for the implementation of healthcare policies. Currently, the funds provided to the provinces and territories are conditional upon different clauses and regulations which hinder the effective implantation of healthcare services.

The main reason for advocacy of private sector by the provinces and territories is the financial burden of healthcare services on the provincial governments. Increased flow of funds from the federal government may reduce the growing need of entry of the private sector in the business of healthcare.

Use of ancillary services like medical insurance, etc. for reducing the burden of expensive health care services on the public is logical and much needed initiative. The government (federal and provincial) may pay a part of the insurance premium to share the load of health care services and reduce the burden of the treasury.

Healthcare has undergone shifts from the era of welfarism to more market-oriented approaches. Access, quality, fairness and cost will always be contentious issues in the Canadian health system. The intergovernmental struggle over healthcare is structured on a Constitutional framework and superimposed with competing political dynamics. 'Collaborative' approach remains the permanent trend for the present and the future.

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